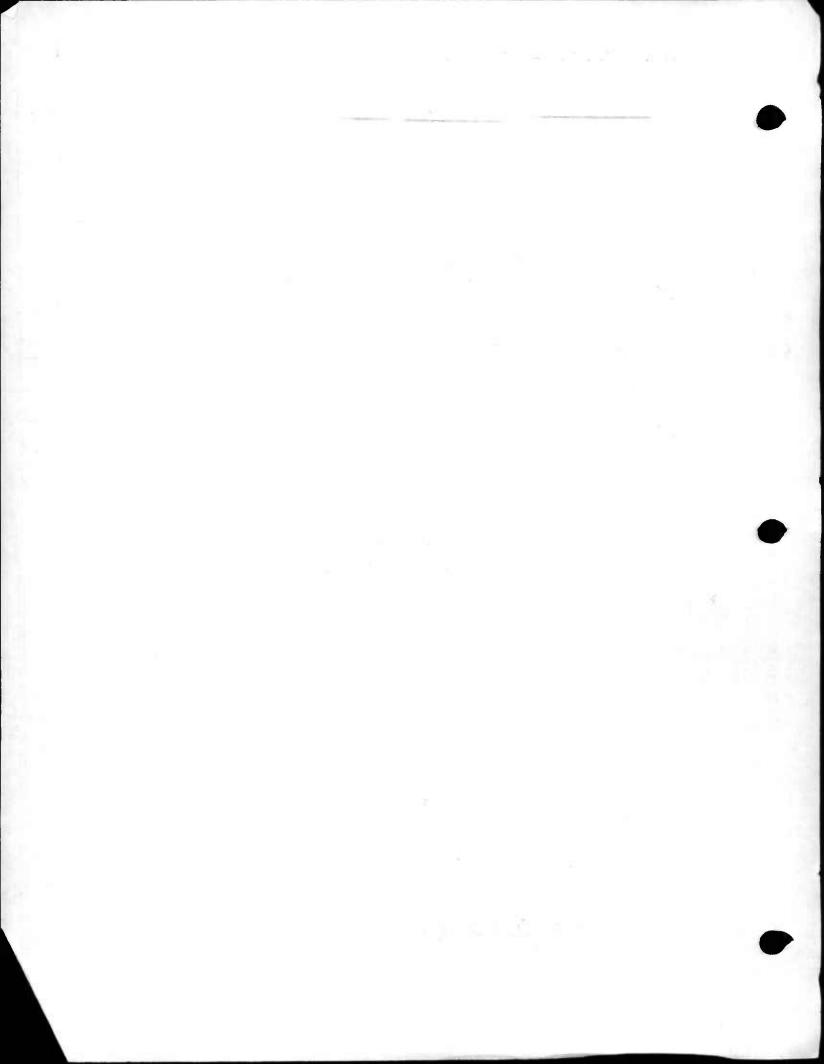
	,	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTMENT			AL HYGIENE REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)	JOSEPH MAIDEN	JRPH Jr	_	2. DATE	of DEATH	95	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 225-20-1255	5. SEX 8. AGE (In yrs. lest birthday) IF UNDER WONTHS WONTHS	R 1 YEAR IF UNDER 24 I	IIN. (Mon	OF BIRTH th, Day, Year)	Cou	THPLACE (State or Foreign ritry)
2, 3 should	OR	Sa. FACILITY NAME (If not institution, give str CHURCH HO	eet and number) ME + H	05P 96. CIT	Y, TOWN OR LOCATION			COUNTY OF	
←	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, TOWN					10d. INSIDE CITY LIMITS?
t permit. Pages		10e. STREET AND NUMBER		Balti	101. ZIP CODE	2 /	10	g. CITIZEN OF	1 → TES 2 → NO WHAT COUNTRY?
-0020 ling physician. the burial-transit	FUNERAL	20 N. Washin 11. MARITAL STATUS 1 Ngver Married 2 Married	12. WAS DECEDENT EVENT		WAS DECENDENT OF H	ISPANIC ORIGI	N? (Specify Yes or I	Vo- 14. RA	S/A/ CE — American Indian, lick, White, atc.
8 g 2	ED BY	3 Widowed 4 Divorced 15. DECEDENT'S EDUC		8 Jan 1946	1 - YES 2 NO	Specify:		Spi	
21 al or for u	COMPLETE	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	18a. DECEDENT'S USUAL O (Give kind of work done life. Do NOT use retired.) Machine	during most of working		vash 419		tar Newspapel
MARYLAND 2 retained by the hospital of 5 should be detached for notified at once.		17. FATHER'S NAME (First, Middle, Last)	len Sr.			'S NAME (First,	Middle, Maiden Surn	ame)	
MARY retained to 5 should notified	то ве	19a. INFORMANT'S NAME (Type/Print)		APPLIA IN IN IN	S (Street and Number or i	Rural Route Nun			
де аде де		20s. MPTHOD OF DISPOSITION	mmons	.PLACE AND DATE OF DISPOS	ucern	Roa		allstow	
'IMOR Page 6 ma Il director, p		1 Surial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val from State	atery, crematory or other place)	rest Ceme	tery 8-3	Cust -		County MI
ALT death. funera		21. SIGNATURE OF FUNERAL SERVICE LICE Runald C			NAME AND ADDRESS OR RUNAULA AI	GRAY	son Fun	eral !	Service. EMD, 2124
n by remo		23. PART I. Enter the diseases, or co	omplications that caused	the death. Do not anter	tha mode of dying,	auch aa car	diec or reepirate	ry arrest,	Approximate interval Between
within 24 hapletely fille cremation,		iMMEDIATE CAUSE (Final disease or condition resulting in death)	Condition DI	^	mies	_			Onset and Deat
68 and co buria	TION	Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):	A .				
O. BOX sertificate be ing physician rigine prior tr	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa	DUE TO (OR AS A	CONSEQUENCE OF):					-
U = BE 9	CER	resulting in deeth) LAST			·				
A and at the	MEDICAL	PART II. Other aignificant conditions	contributing to death be	ut not reaulting in the ur	ndariying cauea give	n in Part i.	24a. WAS AN AUTO PERFORMED 1 - YES 2	17	Bb. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
L RECC law requires as been sign ept. of Healt 23 shows		DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YES	NO 🗀 UNCER	TAIN [7]	`		1 TES 2 NO
	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEATH (Check	only one)				
	PHYS	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?		SCRIBE HOW INJUS	RY OCCURED	
ISION OF TTENDING PHYS TOR: After this of after death with 28 is marked,	B	Netural 5 Pending Investigation 3 Suicide 6 Could not be		— At home, farm, street, fact	1 YES 2 N		CATION (Street and h	lumber or Rure	I Boute Mumber
	ETEC	4 Homicide determined	building, atc. (Speci	* Home		City	or Town, State)	or rura	rioda ramos,
	COMPLETED		IAN: To the best of my knowle On the basis of examination						(s) and manner as stated
분 분 을 등	BE C	286. SACRETORIE AND TITLE OF CERTIFIER	ER.	Physician	29c. LICENSE	NUMBER	296	. DATE SIGNE	D (Month, Day, Year)
₽ ₽ ₽ ¥	9	AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	ATH (FIEM 27) (Type, Print)	1) 29	696		7.6	18.95
4		31. DATE FILED (Month, Day, Year)	REGISTRAR'S SIGNA	ATH MEM 27) (Type, Print) HUNON ATURE	mo				
/		JH 3 1 1995	REGISTRAR'S SIGNA	Rarbell					

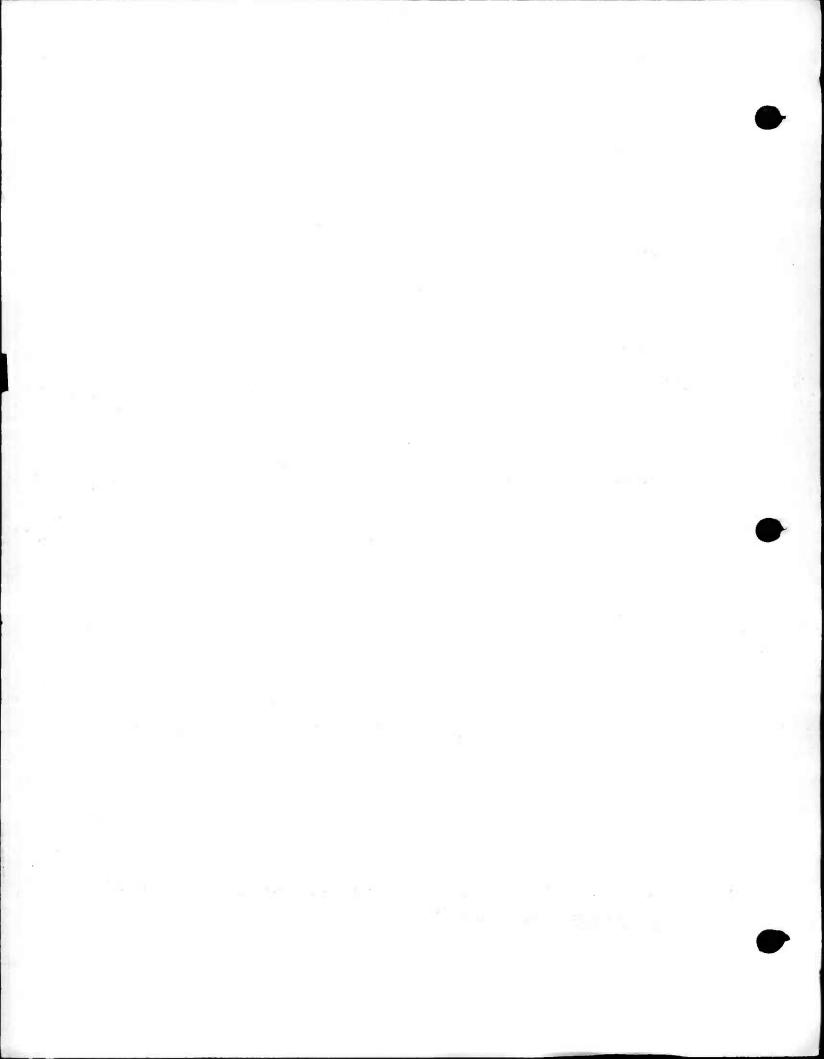


ttending physician. e as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or at 10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be fined within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	EALTH AND	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) PRUDENCE MARY	NICHOLS				2. DATE OF DEATN		3. TIME OF DEATH	
			(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	199	5 0 P M	
	213-34-6388	1 □ M 2 🖔 F 8	36 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) APRIL 26,		BIRTNPLACE (State or Foreign Country) W.VIRGINIA	
œ	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN								
OT.	STELLA MARIS HOSPICE TOWSON RESIDENCE OF DECEDENT						BAL	TIMORE	
DIRECTOR	MARYLAND 106. COUNTY	BALTIMORF	BALTIMORE BALTIMOR BALTIMOR				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	10e. STREET AND NUMBER			101	. ZIP CODE			N OF WHAT COUNTRY?	
INE	1108 GREGORY AVENU	J.E. WAS DECEDENT EVER II	ALLIC ADMED			207	U.S		
BY	1 Never Married 2 Merried 3 XWidowed 4 Divorced	FORCES? 1 YES	2 A NO	If yes, sp	ecify Cuben, Mexico 2 X NO Specif	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) y:	or No- 14	I. RACE — American Indian, Black, White, etc. Specify: WHITE	
ED	15. DECEDENT'S EDUCA (Specify only highest grade co	TION ompleted)	16a. DECEDENT'S	USUAL OCCUPATIO	ON set of working	16b. KIND OF BU	SINESS/INDUS	STRY	
COMPLETED	Elementery/Secondary (0-12) 8TH GRADE	College (1-4 or 5+)		rork done during mo e retired.)		000000	DOODNE	HOVE	
MO	17. FATHER'S NAME (First, Middle, Last)		NUKS	E'S AIDI		CONVALI		HOME	
	SHERMAN RICHMOND					IA PLUMLEY	Surreme		
TO BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street e		Route Number, City or Tow	n, State, Zip Co	ode)	
F	IVA E. McELROY		1108 G	REGORY A	AVENUE -	BALTIMORE	, MD	21207	
	20a. METNOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Remove 4 Donetion 5 Other (Specify)		PLACE AND DATE OF				CATION — CITY KESVIL	y or Town, State	
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE 1		22. NAME AN	D ADDRESS OF FA				
	> 11. Tleas	Colone				AVENUE-BAL'		.MD 21229	
	23. PART i. Enter the diseases or con shock, or heart fellure. Lie	mplications that caused at only one cause on a	tha daath. Do n	ot antar tha mo	da of dying, suc	h as cardiac or reapi	ratory arrea	Approximata	
	IMMEDIATE CAUSE (Final disease or condition resulting in desth) **LUNG CANCER - SQUAMOUS CELL 3.05.								
	DUE TO (OR AS A CONSEQUENCE OF):								
0 N	Sequantisity list conditions, DUE TO (OR AS A CONSEQUENCE OF):								
CAT	if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury								
TE	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION	d.								
	PART il. Other significant conditions	contributing to death b	ut not reaulting in	n tha undariying	cause given in	Part i. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
)d						1 _ YES 2	X NO	CDMPLETION OF CAUSE DF DEATH?	
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRI	RIITE TO CALISE O	E DEATH VE	S X NO [UNCERTAI			1 TES 2 NO	
IAN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT		UNCERIAI				
SIC		HOSPITAL:	atlent 3 DOA	OTHER: 4 - Nursing Hom	5 🗆 Residence	6 NOther (Specify)	HOSPICI	E	
FH	27. MANNER OF DEATN 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Yeer)	28b. TIME		URY AT RK?	28d. DESCRIBE HOW I		~~	
B	2 Accident Investigation	284 PLACE OF INJURY	- At home form	M 1 1					
COMPLETED	3 Suicide 8 Could not be 4 Nomicide determined 28e. PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Right City or Rown, State)							Rural Route Number,	
PLE	290. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my knowl	ledge, death occurre	d at the time, date	and piece, end due	to the ceuse(e) end mer	ner as stated.		
Ö								ceuse(a) end menner ee stated.	
H	296/SIGNATURE AND TITLE OF CERTIFIER CHARLE FAMILIEUM 29c. LICENSE NUMBER 29d. DATE SIGNED (Morgin, Day, Year) 7/31/95								
5	30. NAME AND ADDRESS OF PERSON WHO O		ulaney V		l. Tows	on, Marylar	nd 212	7	
	31. DATE FILED (NA 11 1995 Jul	132 House Par	elall,						
	70[9 T 1922 Am		1/10						



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
ISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	ENT OF H	EALTH AND DEATH		YGIENE EG. NO.		. 0 0 0 0	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF I	DEATH	(22)	3. TIME OF DEATI	н
	ESTELLE W.	OWENS				JULY	25,	1995	11:04	Ам
	4. SOCIAL SECURITY NUMBER		MO	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF E (Month, De	v. Yhar)	Count	PLACE (State or For	eign
	217-07-5142 9a. FACILITY NAME (If not institution, give atr		5 YRS.		25000	JUNE	8,191		9PY CAL	19
Œ	THE JOHNS HOPKINS				R LOCATION OF D	EATH	1	e. COUNTY OF D	EATH	
DIRECTOR	RESIDENCE OF DECEDENT	HUSPITAL			E CITY			n/a		
E	MARYLAND 106. COUNTY	n/2		OWN OR LOCAT	1242				10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER	n/a	B	ALTIMO	ZIP CODE			log. CITIZEN OF V	1XX YES 2 1	10
FUNERAL	1813 ASHLAND A	VENUE			21205	5		UNITED	STATES	
N I		12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (S	pecify Yaa or	No 14. RACI	E — American India	n,
BY	1 Never Married 2 Married 3 Widowed 4 XXDivorced	IF YES, GIVE WAR OR DAT	ES	1 TYES	2 NO Speci		i, etc.)	Speci	White, etc.	
	15. DECEDENT'S EDUC	ATION	16a. DECEDENT'S USU	AL OCCUPATIO	N .	16b. KIN	D OF BUSIN	ESS/INDUSTRY	DEACK	
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use ret	done during mos ired.)	st of working					
MP	12 TH	-	LAUNDRY	WORKE	R	BU	GLE	LAUNDRY		
	17. FATHER'S NAME (First, Middle, Last) JACOB FORD				18. MOTHER'S NA					
B	19a. INFORMANT'S NAME (Type/Print)		195 MAILING ADD	DESS /Street a	JAL nd Number or Rural			IGHT		- 3
5	LAWRENCE PUL	LEY	1 1011	N. BOI				ORE, MD	21213	
	20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ramon		PLACE AND DATE OF DI			DATE		TION — City or To		
	4 Donation 5 Other (Specify)		RBUTUS		AL PARK		ARBU	TUS, MAI	RYLAND	
	► Lalan	do dal	0		C. MARCH		1 ∩ 1	E. NORTI	H AVEN	UE
	22 PADT Enter the diseases or or	wa you	cana	/					AVEN	02
		lat only one cause on ee	the deeth. Vo not e ch lina.	enter the mod	de of dying, suc	ch aa cardlec	or reapirat	ory arrest,	Approxima Interval Be	tween
1	IMMEDIATE CAUSE (Finel disease or condition produting in death)							Death		
İ	a. a spiration of gastric searctions into lung 10 minutes DUE TO OR AS A CONSCOUENCE OF):									
NO	Sequentially list conditions, Due to (or as a consequence or):							4		
Ä	If any, leading to immediata cause. Enter UNDERLYING		er - v	note o	trace	200	no A	2000	1	4.
ĬĘ	CAUSE (Disease or Injury that initiated evente	DUE TO (OR AS A C	CONSEQUENCE OF):	TCIUS	14313	or Co	u Cry	Notal	Ginor	rivis
CERTIFICATION	resulting in desth) LAST	-								
	PART II. Other eignificant conditions	contributing to deeth but	not reaulting in th	e underlying	ceuee given in	Part I. 24a.	WAS AN AU	TOPSY 24b.	WERE AUTOPSY FIN	DINGS
MEDICAL						10	YES 2 [AVAILABLE PRIOR TO COMPLETION OF CA OF DEATH?	
ME						_ ′			1 YES 2 NO	,
PHYSICIAN:	DID TOBACCO USE CONTRI				UNCERTAI	N 🗆		4		
ž Į		HOSPITAL:		HER:						-
HYS	1 YES 2 XNO 27. MANNER OF DEATH	1 Dinpatient 2 ☐ ER/Output 28s. DATE OF INJURY	lent 3 DOA 4 28b. TIME OF	Nursing Home 28c. INJU	5 Realdence	8 Other (Spe 28d. OESCRIB		IBY OCCUPED		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WOF	ES 2 NO		2 11011 11100	OCCURED		
	3 Suicide 6 Could not be	28a. PLACE OF INJURY - building, atc. (Specify	- At home, farm, street	, factory, office		28f. LOCATION City or Tox	(Street and	Number or Rural R	loute Number,	
	4 Homicide determined					0.1,7 0.7 1.0.7	rn, olale,			
2er. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2er. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2er. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2er. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2er. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2er. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2er. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
	29b. SIGNATURE AND TITLE OF CERTIFIER	Of the basis of examination (ind/or investigation, in	my opinion, de						ted.
B	1 CINALO (1)	land. 0. 1	nn		29c. LICENSE NUI	MBER 44	25	DATE SIGNED	(Month, Day, Year) 25, 1995	-
2	30. NAME AND ADDRESS OF PERSON WHO				1110	/ 1		Jary	20,1713	
	6226B Gree		PKWY	Balt	-mo	2120	9			
	31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S CONA	Ung							
- 11	301 0 7 1000									- 1

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL OR ATT

223

PHYSICIAN: MEDICAL

BY

COMPLETED

BE

2

TO THE HUSPITAL OR ALTENDING PHYSICIAN: THE LAW (EQUITES THAT THE DESITY CENTINCATE OF EXECUTED WITHIN 24 HOURS ATTENDED OF THE HOSPITAL OF THE HOSPITAL OF ATTENDING PHYSICIAN: THE LOSPITAL OF THE HOSPITAL OF ATTENDED BY THE HOSPITAL OF ATTENDED BY THE HOSPITAL OF ATTENDED BY THE HOSPITAL OF THE HOSPI	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.	filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
2	2	20	Ξ

CAUSE (Diseese or Injury

that initiated events resulting in death) LAST

1 YES 2 NO

27. MANNER OF OEATH

1 Natural

2 Accident

3 Suicide

4 Homicide

95 23004 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH
MONTH

JULY
Z 3. TIME OF DEATH YEAR 8:30 LRENE 29 \mathcal{F}_{\cdot} KOEHNBR 7. DATE OF BIRTH (Month, Day, Year)

JULY 9 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 F 219-22-3178 11909 MARYLAND 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MERIDIAN NURSING CENTER CATONSVILLE CATONSVILLE DIRECTOR BALTIMORE 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY LIMITS? BACTIMORE MARYLAND ARBUTUS 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 101, ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? 21227 STATES 1233 LINDEN AUE WITED 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuben, Maxican, Puerto Rican, atc.) 14. RACE — American Indian Black, White, atc. 1 Never Married 2 Married Specify: WHITE 1 TYES 2 NO Specify: В 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elamentary/Secondary (0-12) College (1-4 or 5+) DOMESTIC HOMEMAKER 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) GEORGE SWANN DISNEY HATTIE BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 IRENE M KOEHNER LINDEN AVE BALTIMORE 21227 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Burial 2 Cremation 3 Rame BALTIMORE CEDAR HILL C MD Oonation 5 - Other (Specify) EMETERY 22. NAME AND ADDRESS OF FACILITY CAFA STEPHEN D. LOHRMAN 23. PART I. Efter the diseases, of complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory errest, 8717 GREEN PASTURES DR BATIMORE MD 21286 Approximata ehock, or haert failure. List only one ceuse on each line. Interval Batwean IMMEDIATE CAUSE (Finel Onset and Death YOCARD disesse or condition resulting in desth) C EYERE DRONAR CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING

PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. REGURGITATION TRICUSPID REGURBITATION INSUFFICIENCY INFEROLAT, ISCHENIA

DUE TO (OR AS A CONSEQUENCE OF):

24a. WAS AN AUTOPSY PERFORMEO? 1 | YES 2 | NO

28d, OESCRIBE HOW INJURY OCCURED

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO OF OFATH? 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Box\) NO \(\Box\) UNCERTAIN \(\Box\) 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?**

26. PLACE OF DEATH (Check only one) 5 Residence 6 Other (Specify)

OTHER 4 Nural 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. OATE OF INJURY

28b. TIME OF INJURY 28c. INJURY AT WORK? м 1 TYES

26s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the (Check only one) 2 MEDICAL EXAMI

29c. LICENSE NUMBER RE AND TITLE OF #1

D16200

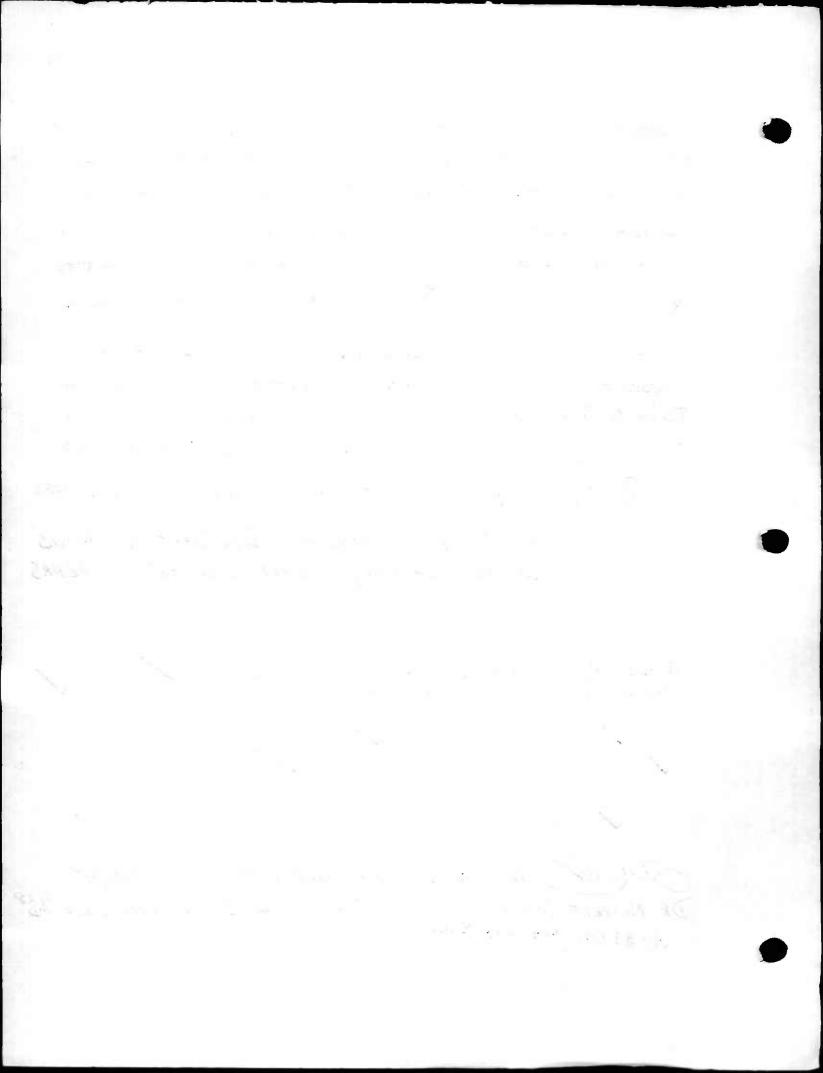
29d. DATE SIGNED (Month, Day, Year)

Investigation

8 Could not be

31. DATE FILEO (Month, Day, Year)

JUL **3 1** 1995



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

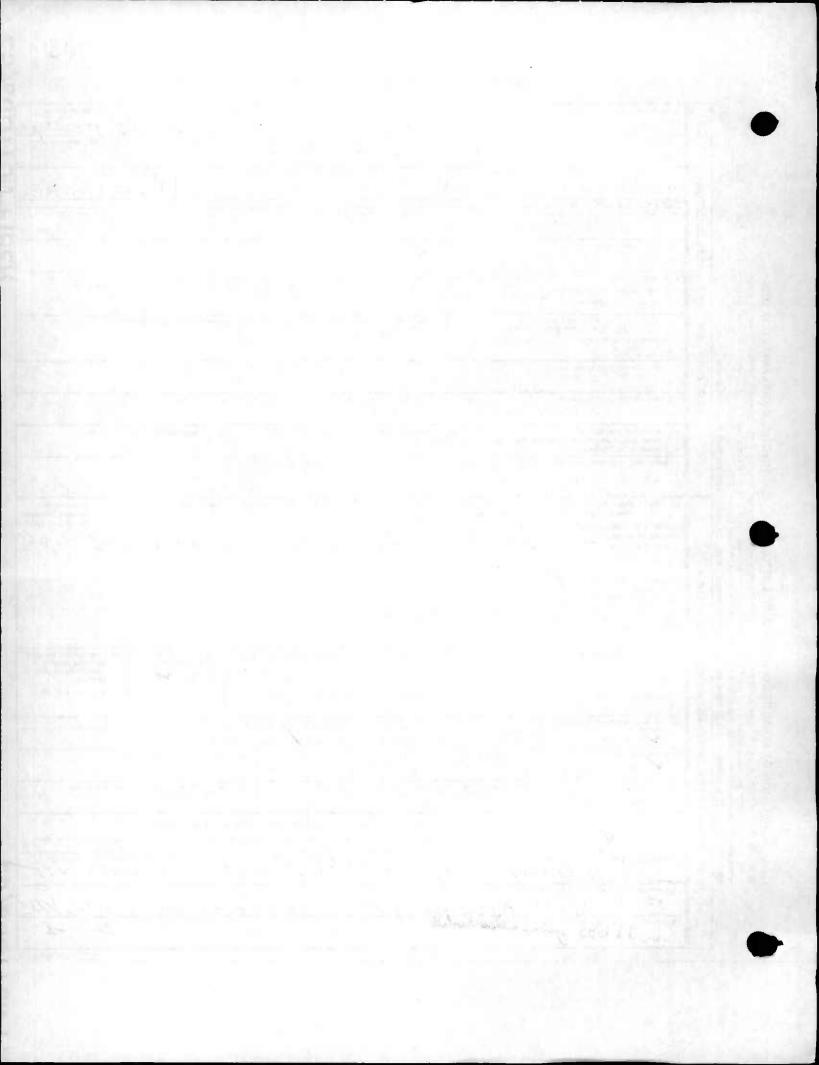
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the most of the Hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF	MARYLAND /	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIEI	NI
	CI	ERTIFICATE	0	F DEAT	H		REG NO	2

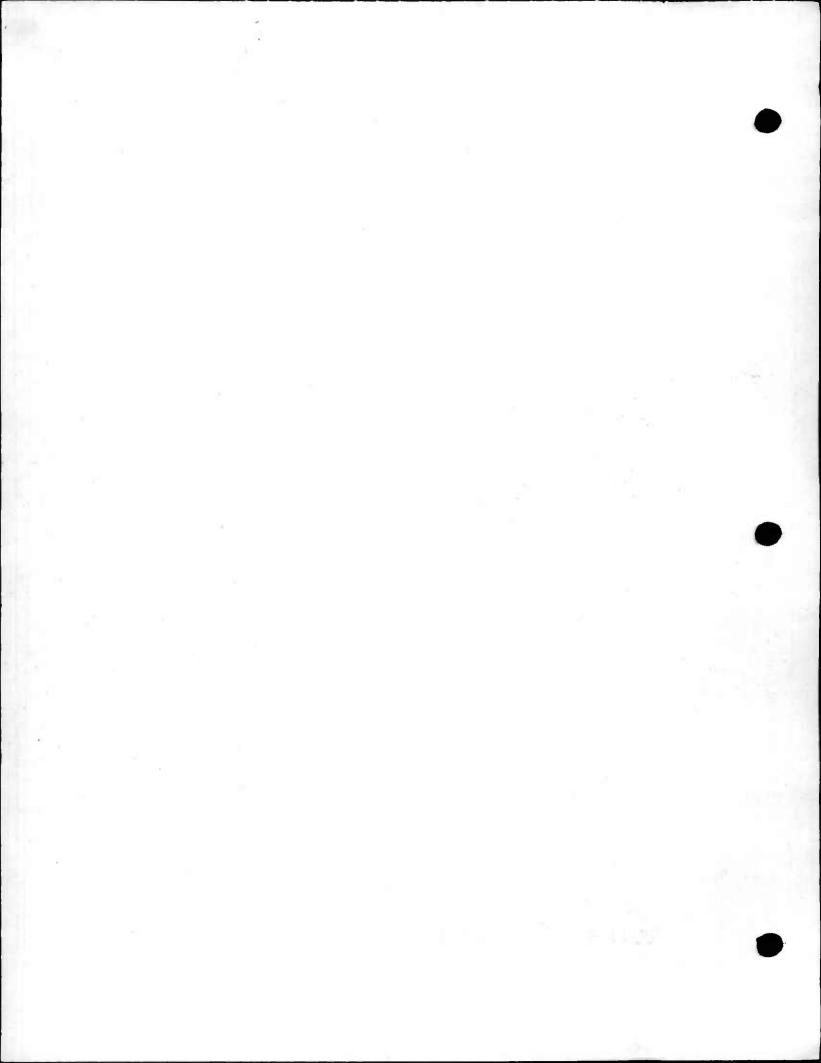
	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last) MICHAEL A. ROMEO,				2. DATE OF DEATH	- 4	
	127 05 0501	1 ☑ M 2 □ F 8	1 YRS.	UNDER 1 YEAR IF UNDER 24 HRS NTHS DAYS HOURS MIN.	JULY 4, 191	4 MÃ	OUTHPLACE (State or Foreign Ountry) ARYLAND
TOR	9e. FACILITY NAME (If not Institution, give str 4138 ANNAPOLIS RO			BALTIMORE	DEATH	TIMORE	
DIRECTOR	MARYLAND BAL	TIMORE	10c. CITY, T	BALTIMOR	Е	10d. INSIDE CITY LIMITS? 1 YES 24 NO	
FUNERAL	4138 ANNAPOLIS RO	NNAPOLIS ROAD - APT-B-1			7	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS OECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR D.	2X NO	13. WAS DECENDENT OF HISP If yes, specify Cuben, Mex 1 YES 2 NO Spe	ican, Puerto Rican, etc.)	E	tACE — American Indian, Bleck, Whits, etc. Specify: WHITE
COMPLETED	15. DECEOENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN 16a. DECEOENT'S USUAL C (Give kind of work done life. Do NOT use retired.) BARTENDER			done during most of working tired.)	186. KIND OF BU	SINESS/INDUSTR	w .
BE CON	17. FATHER'S NAME (First, Middle, Lest) VINCENT ROMEO				NAME (First, Middle, Malden KNOWN	Sumame)	
TO B	196. INFORMANT'S NAME (Type/Print) MICHAEL A. ROMEO,	JR.	196. MAILINO AD 105 NU	RSERY ROAD -	BALTIMORE,	m, State, Zip Code MD 2	21090
CAL CERTIFICATION	23. PART I. Enter the diseases, or conshock, or heart failure. L. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent conditions	DUE TO (OR AS A	A CONSEQUENCE OF): A CONSEQUENCE OF):	ric CARDio.	AVENUE-BAL	TIM ORE	Approximate Interval Between Onset and Death
PHYSICIAN: MEDICA					1 NES 2		AAALABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO
/SICI/		HOSPITAL: 1 Inpatient 2 ER/Outp		26. PLACE OF DEATH (THER: Nursing Home 5 (V Residence			
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME O	F 28c. INJURY AT WORK? M 1 YES 2 NO	JURY AT 28d. DESCRIBE HOW INJURY OCCURED DRK?		D
	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, atc. (Spec	/ — At home, farm, stre-	281. LOCATION (Street City or Town, State)	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
TO BE COMPLETED		on the besis of examination		the time, dets and place, and do n my optnion, death occured at the graph of the state of the st	he time, date and plecs, ar	d dus to the csu	NED (Month, Day, Year)



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100 CT 10	fter death, Page 6 may be retained by the hospital or attending physician.	the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should loval.	ai examiner must be notified at once.	
	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merial Hygiene prior to bunial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY DHYSICIAN: MEDICAL CERTIFICATION

	1 - FOR STATE REGISTRAR	STATE OF MARYL		IT OF HEALTH AND	MENTAL HYGIENE REG. NO.	70 20000		
	1. DECEDENT'S NAME (First, Middle, Last) REBECCA		SMITH		2. DATE OF DEATH MONTH DAY	9 YEAR 13 20 M		
	4. SOCIAL SECURITY NUMBER 243-56-7038	5. SEX 6. AGE	yrs last birthday) IF UND YRS. MONTHS	ER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country) S. C.		
LOR	90. FACILITY NAME (If not institution, give st Northwest H	neet end number) OSPITAL	9b. CC	ondalktuw		Balto .		
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d.							
FUNERAL	100. STREET AND NUMBER	lington A	venue 400	101. ZIP CODE 2/2/	7 10g.	1 ØYES 2 □ NO CITIZEN OF WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic 1 YES 2 NO Speci		14. RACE — American Indian, Black, White, etc. Specify:		
	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S USUAL (Give kind of work don	during most of working	18b. KIND OF BUSINESS	MNDUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+) NA	Mursing	Aid	Hos	pital		
BE CO	17. FATHER'S NAME (First, Middle, Last)	ison	<i>y</i>	18. MOTHER'S N.	AME (First, Middle, Maiden Surnen 5+ukle)	, 7-9)		
10	190 INFORMANT'S NAME (Type Spint)	Falcon	196. MAILING ADDRE	SS (Street end Number or Rural Walling)	Route Number, City or Town, State	Zip Code) Balt Mal 2 12 15		
	20e. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remo	2 d b	PLACE AND DATE OF DISPO	SITION (Name of	DATE 20c. LOCATION	H-City or Town, State		
	21. SIGNATURE OF PUNERAL SERVICE LIC	March	1 22	LANGE AND ADDRESS OF F.	ACILITY /	Balto Med 2/2/5		
	23. PART if Enter the diseases, or c shock, or heart fellure. I	omplications that caused List only one cause on a	the death. Do not ente	er the mode of dying, such	ch as cardiac or reapiratory	Approximate interval Between		
	iMMEDIATE CAUSE (Final disease or condition resulting in death) S. PEUMON/A 2 DA7S. OUE TO (OR AS A CONSEQUENCE OF):							
LION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):							
CERTIFICATION	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF):							
	-							
PHYSICIAN: MEDICAL	PART II. Other significant conditions	contributing to death of	ut not resulting in the L	indarlying cause given in	Part I. 24a. WAS AN AUTOP PERFORMED?	AWILABLE PRIOR TO		
N: M	DID TOBACCO USE CONTR	NBUTE TO CAUSE O	F DEATH YES	NO UNCERTAI	ΕŲΝ	1 TES 2 DONO		
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 700	HOSPITAL:	28. PLACE OF OEATH (Checo		8 Cher (Specify)			
ВУ РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJURY	OCCURED		
	3 Suicide 8 Could not be 4 Homicide datermined	28e. PLACE OF INJURY building, etc. (Speci	— At home, farm, street, fa	ctory, offica	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLETED					to the couse(s) end manner es time, date end place, end due i	stated.		
8	29b. SIGNATURE AND TITLE OF CERTIFIER	らんら		29c. LICENSE NU	MBER 29d. 1	DATE SIGNED (Month, Day, Year) JULY 26 (95		
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type, Print)		1021133			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	TURE		7			
	JUL 3 1 1995 A	W DIMBHOLINGS	74.46					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within in the finisher integral role and completely in the president physician and completely

DR. D'Sou 31. DATE FILED (Month, Day, Year)

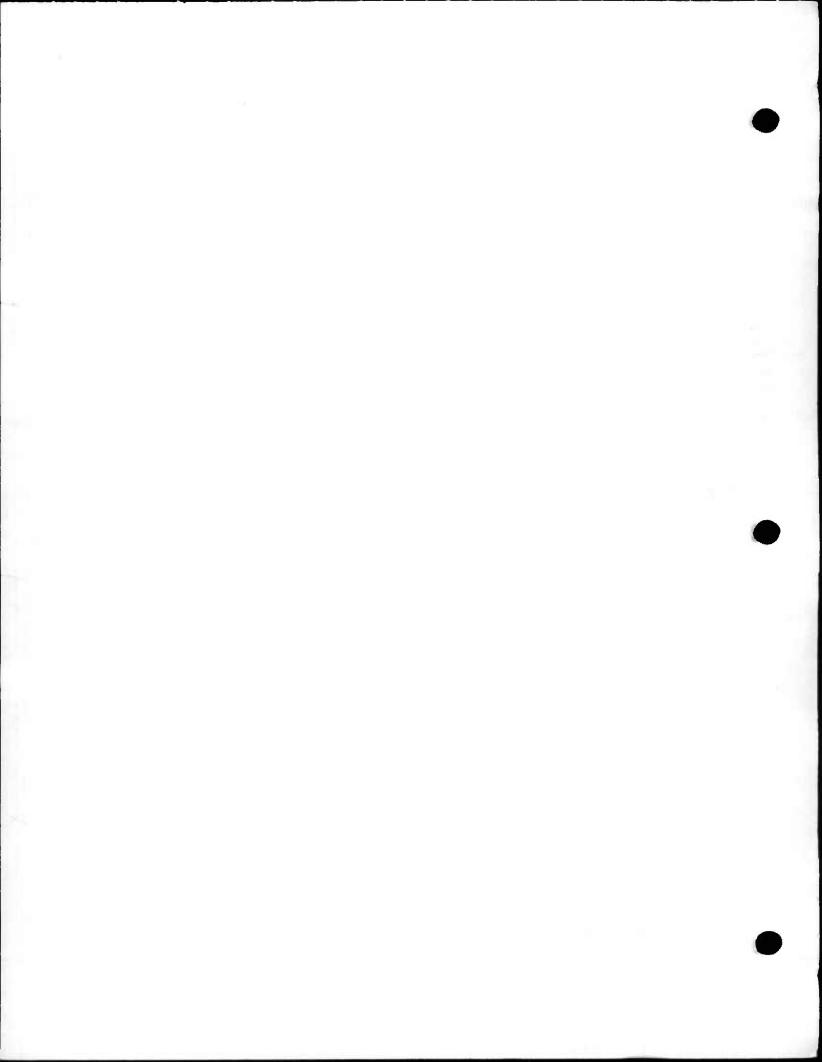
JUL **3 1 1995**

32. REGISTRAR'S SONATURE

Hospital.

Baltimose

								95	23007
		1 - STATE REGISTRAR	TATE OF MARYLA	ND / DEPAR CERTIF	RTMENT OF	HEALTH AND	MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Last) FREEMAN	SPEIL				2. DATE OF DEATH		3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 5. S	SEX 6. AGE (In	yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
		90. FACILITY NAME (If not institution, give street a	M 2 F	87 YRS.		OR LOCATION OF DE	NOU 5, 19	707	N.C.
	TOR	STAGNE HUS	pital		Balt	more	- Alm		OF DEATH NA
	DIRECTOR	10e. STATE 10b. COUNTY	NA	10c. CIT	TY, TOWN OR LOCA	TION			10d, INSIDE CITY LIMITS?
		10e. STREET AND NUMBER	1014	1	Daltim	1. ZIP CODE		tog. CITIZE	1 X YES 2 NO
	FUNERAL	29/2 Maylule 11. MARITAL STATUS 12.	WAS DECEDENT EVER IN I	I S A PRAFE	1,0 000 05	21230			4.5.19
	BY	1 Never Married 2 Married	FORCES? 1 YES	2 X NO	If yes, s	CENDENT OF HISPAN Hecity Cuben, Mexica 3 2 NO Specify	NIC ORIGIN? (Specity Yearn, Puerlo Rican, etc.)	e or No.— 14	RACE — American Indian, Black, White, etc. Specify: Black
	TED	15. DECEDENT'S EDUCATIO (Specify only highest grade comp	leted)	18e. DECEDENT'S (Give kind of life, Do NOT u	USUAL OCCUPAT work done during m	ON ost of working	16b. KIND OF BU	ISINESS/INDUS	TRY
ed	COMPLET	Thegrade	NA NA		remar		Lon	gshor	eman
be notified at once.		17. FATHER'S NAME (First, Middle, Last)	Spell			Saras	ME (First, Middle, Meider		
notified at	TO BE	190. INFORMANT'S NAME (Type/Print)	1	19b. MAILING	ADDRESS (Street		Route Number, City or Tov	1	de)
t be n		200. METHOD OF DISPOSITION	29b\ F	PLACE AND DATE	OF DISPOSITION (N	amo of -	ad Da	CATION - CIT	2/230 y or Town, Stata
er must		1 Suriel 2 Cremetion 3 Removal (4 Donation 8 Other (Specify) 21. SIGNAUPIL OF FUNERAL SERVICE LICENSE	demin	ery, crematory or d	atimo	PR.	81/95	aure	1 0
or removal. medicai examiner	ų,	- Dlemis	B. Lc	oth	Man Har	ND ADDRESS OF FA	West Dine	Ra	Ha 41/ = 120
or remova medicai		23. PART I Enter the diseases, or comp shock, or heart fellure. List	ilcetions that ceused tonly one cause on each	the deeth. Do i	not enter the me	de of dying, auci	h aa cerdiec or resp	iratory arres	h, Md ZIZIS Approximate Interval Between
the n	ì	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Dueum	AL IA					Onset end Death
event		DUE TO (OR AS A CONSEQUENCE OF): H LIERTEWTOOK,							
r to bur	CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):							
her tra	FICA	CAUSE. (Disease or Injury thet initiated events DUE TO (OR AS A CONSEQUENCE OF):							
al Hygie	ERTI	resulting in deeth) LAST							
of Health and Mental Hygiene prior to burial, cremation, shows any injury, or other traumatic event, the		PART ii. Other aignificent conditions con	ntributing to deeth but	not resulting	In the underlyin	g ceuse given in	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ws any	MEDICAL						1 □ YES		COMPLETION OF CAUSE OF DEATH?
3 sho		DID TOBACCO USE CONTRIBL	ITE TO CAUSE OF	DEATH YE	S NO [UNCERTAIN	v 🗆		1 TYES 2 NO
State Dept. or item 23 sl	SICIA		SPITAL:		OTHER:				
ed, or	PHYSICIAN:	27. MANNER OF DEATH	Inpatient 2 ER/Outpati 28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. IN.	URY AT	8 Other (Specify) 28d. DESCRIBE HOW	NJURY OCCUR	ED
death with the	BY	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could get be	280. PLACE OF INJURY -		M t 🗆	YES 2 NO	201 LOCATION (Committee		
after 28 is	ETED	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Specify)			281. LOCATION (Street City or Town, State)	and Number or	nurai Houte Number,
2 =	COMPLE		To the best of my knowled						
be filed within 7	E CO	2 MEDICAL EXAMINER: On	The basis of exemination e	end/or investigation	n, in my opinion, o	eath occured at the 29c. LICENSE NUM			ause(s) and manner se stated. GNED (Month, Day, Year)
iMPO	O BE	X	WXall	64		D 76		▶ 7	125/95
	- 1	30. NAME AND ADDRESS OF PERSON WHO COI	WEETED CAUSE OF DEAT	H (ITEM 27) (Type,	Print)				1



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YEAR 3. TIME OF DEATH
1995 11:15 A.W
6. BIRTHPLACE (State or Foreign Country) 3 Maryland
c. COUNTY OF DEATH
Baltimore County
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
Og. CITIZEN OF WHAT COUNTRY?
No- 14. RACE — American Indien, Black, White, etc.
Specify: White
ome
tate, Zip Code)
21244 ION — Cify or Town, State
lawn, MD
ctors, Inc.
town, MD 21133
Approximate intervel Between Onsat and Death
70A-15
DOOY AND WEST AND AND THE STATE OF THE STATE
TOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
D? AVAILABLE PRIOR TO COMPLETION OF CAUSE
D? AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
D? AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
D? AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
D? AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
D? AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RY OCCURED Number or Rural Route Number,
P 0 0 1

32. REGISTRAR'S SIGNATURE



31. DATE FILED (Month, Day, Year)

JUL 3 1 1995

nite

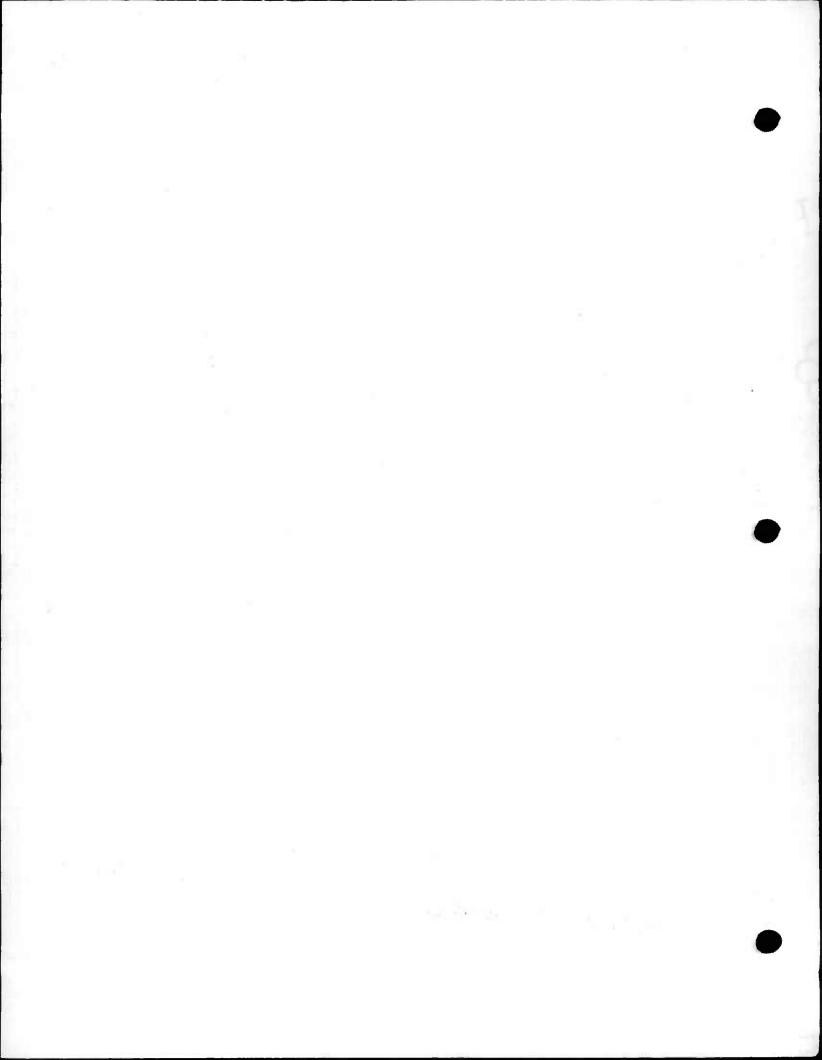
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oodlawn, MD
Directors, In
andalistown, MD

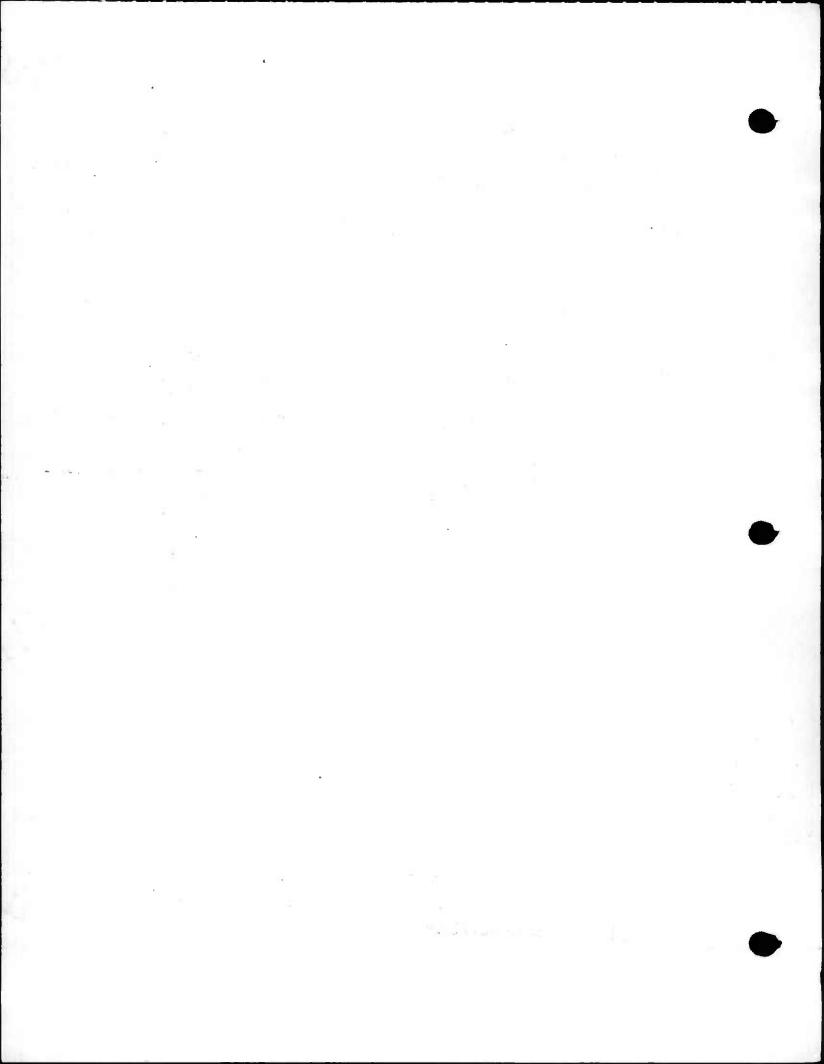
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Nental Hygher prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event. The market has notified at page.

									95	2	3009	
	FOR STATE REGISTRAR	STATE OF MA	ARYLAND /	DEPAR ERTIF	TMENT OF	HEALTH A	ND ME	NTAL HYGIEN REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)	L.					2.	DATE OF DEATH DA		YEAR	3. TIME OF DEATH	
	Calvert 4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. last birth			HULTZ	R IF UNDER 24		July 28		995	8:00	a ^M
	214-38-0709 9a. FACILITY NAME (If not institution, give s	1-2M 2 □ F	54	YRS.	MONTHS DAY	8 HOURS	MIN.	(Month, Day, Year) 4-27-194	1	Country [ary]	Land	n
E I	Franklin Squar		:a1		96. CITY, TOW	N OR LOCATION	OF DEATH	4	9c. COUN			
5	RESIDENCE OF DECEDENT		, u . L					Baltimore County				
DIRECTOR	Maryland 10b. count	N.A.		10c. CIT	Balti		10d. INSIDE CITY LIMITS? XX YES 2 NO					
FUNERAL	3706 Chestle P	lace				101. ZIP CODE 21224			10g. CITIZ		NAT COUNTRY?	
B	11. MARITAL STATUS 1 Never Married 2 1 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	YES 2KIN	MED	If yes,	Specify Cuben,	Mexicen, P	ORIGIN? (Specify Yes tuerto Ricen, etc.)	or No-		- American Indien, White, etc.	
윤	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(G)	ive kind of t	USUAL OCCUP	ATION most of working		16b. KIND OF BUS	SINESS/INDU	JSTRY		
COMPLETED	Elementary/Secondary (0-12) 12 Years	College (1-4 or 5+) N . A .	Ille.	Welc	se retired.)			Beth1e	hem	Ste	el	
BE COI	17. FATNER'S NAME (First, Middle, Last) Albert	Schultz				Naom:		(First, Middle, Maiden Gi	Sumame) bson			
6	19e. INFORMANT'S NAME (Type/Print)		191	. MAILING	ADDRESS (Stre	et end Number or	Rural Rout	e Number, City or Town	n, State, Zip	Code)		
-	Marie Schul	tz					ace	Balto.	Md.	212	24	
	20s. METHOD OF DISPOSITION 5 Burlel 2 Cremation 3 Rem	ovat from State	20b. PLACE A cemetery, crei	ND DATE (OF DISPOSITION ther plece)	(Name of			CATION — C			
	Commercial Commercia											ıd
	· Wharl	Bown	nen		Jos	eph N.	Za	nnino J	r. F Stre	une:	ral Home Balto. M	61
	23. PART I Enter the diseases, or shock, or heart failure.	complications that	ceused the de	ath. Do r	ot enter the	mode of dying	, auch e	a cardiac or reapi	ratory erre	st,	Approximate interval Between	
	IMMEDIATE CAUSE (Final disease or condition	meeting continues					_				Onset and De	
	resulting in death) a										48 Hour	:s
z	DUE TO (DR AS A CONSEQUENCE OF): Metastatic Melanoma 3 Years											
CERTIFICATION	f any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
ICA	CAUSE (Disease or Injury	C	2 40 4 001000									
Ė	that initiated events resulting in death) LAST	DUE TO (O	R AS A CONSEC	IUENCE OI	F):							
S		d										
PHYSICIAN: MEDICAL	PART II. Other algnificent condition	e contributing to d	eeth but not re	eauiting	in the underly	ring ceuse give	en in Par	t i. 24a. WAS AN PERFOR	MED?		WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE	4
ME									X		OF DEATH?	
ä	DID TOBACCO USE CONTI	RIBUTE TO CAU					RTAIN [
Sic.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:							\exists
Η	1 TYES 2 NO 27. MANNER OF DEATH	1 M Inpetient 2 □ E		28b. TIM		ome 5 - Reeld		Other (Specify) d. DESCRIBE NOW IN	IIIIDY OCCI	IBED		_
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	Year)		URY	WORK?		a. DESCRIBE NOW II	SONT OCC	JALO		
COMPLETED B	3 Suicide 8 Could not be determined	28e. PLACE OF building, at	NJURY — At hor c. (Specify)	me, farm, s	street, fectory, o	ffice	28	1. LOCATION (Street a City or Town, State)	nd Number o	or Aurel Ro	oute Number,	╗
Ž	29a. CERTIFIER (Check only 1 🗶 CERTIFYING PHYSI	CIAN: To the best of m	v knowledge des	ith accum	ed at the time of	ete and place or	ad due to ti	ha counciles and man				-
OME	(Check only one) 2 MEDICAL EXAMINE										end menner ee stated.	
	295. SIGNATURE AND TITLE OF CERTIFIER					29c. LICENS					Month, Day, Year)	\dashv
TO BE	30. NAME AND ADDRESS OF PHISON WN	D COMPLETED CAUSE	OF DEATH (ITEM	27) (Type	Print)	d1848			Jul	y 2	8, 1995	_
	Myo Thant MD	9000 Frank	lin Car	uare	Drive,	Baltin	nore,	Maryland	1 212	37		
	JUL 31 1995	J. Mandan	SMINANTE								<u> </u>	

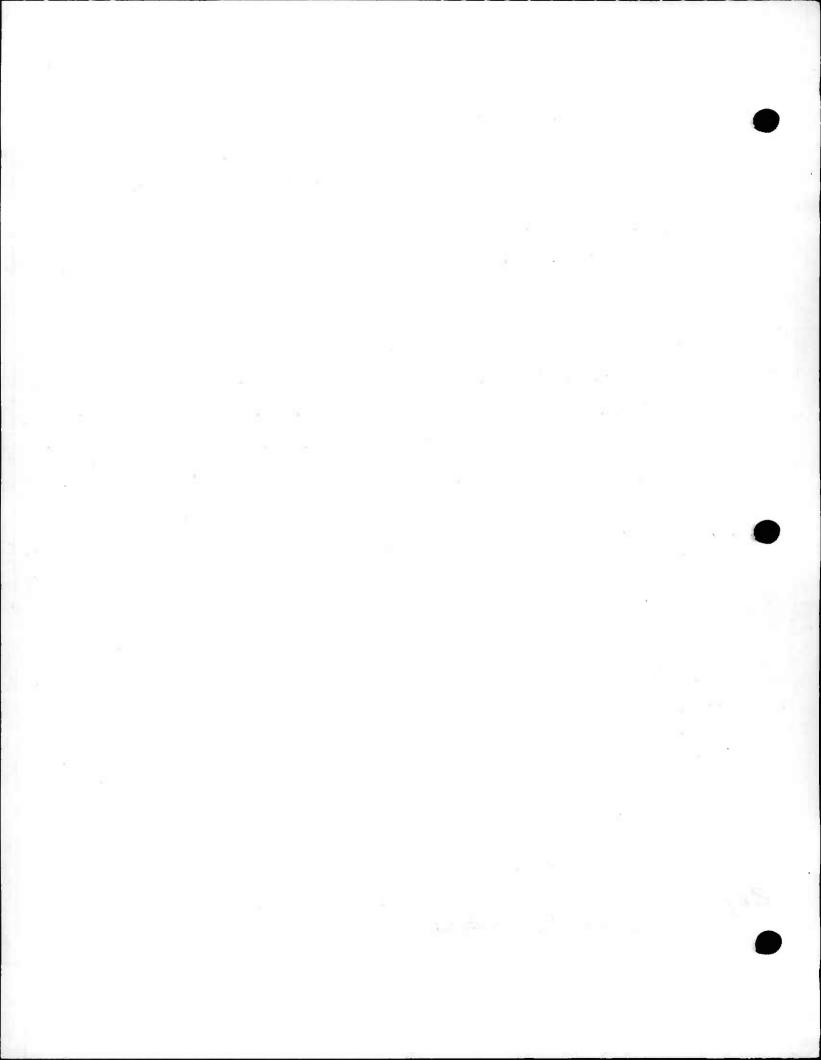


		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AI CERTIFICATE OF DEATH	
		1. DECEDENT'S NAME (First, Middle, Last) LULL APLYCUS	2. DATE OF DEATH MONTH: DAY
	2	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 2/3 - 24 - 27 45 1 M 2 F YRS. MONTHS DAYS HOURS IN	HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Main. (Month, Dal, Year) 928 (Quinty)
3 should	<u>«</u>	9e. FACILITY NAME (if not institution, give street end number) 9b. CFTY, TOWN OR LOCATION	OF DEATH 9c. COUNTY OF DEATH
Pages 1, 2,	RECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY TOWN ON LOCATION	10d. INSUME CITY
permit. Pa	AL DIRE		1 P YES 2 NO
ian. transit	FUNER	2118 1). Rose dale Street 210	IISPANIC ORIGIN? (Specify Yes or No. 14. RACE - American Indian,
	BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES	Maxican, Puerto Ricen, etc.) Specify: Bleck, White, etc. Specify: ACK
or afte	ETED.	(Specify only highest grade completed) [Secondary (1.2)]	16b. KIND OF BUSINESS/INDUSTRY
AND the hospital detached fo	COMPL	17. FATHER'S NAME (First, Middle, Last) 19. Midd	US State of Md,
retained by the 5 should be notified at	BE	194 INFORMANT'S NAME (Appa(Prior))	TINA HOPKING
y berny berny berny berny berny	0	Leismand Spencer 2118 Kored 294 PLACE AND DATE OF DISPOSITION INSIGNO OF	Ale St SATO Md 2/2/6
e 6 m ector.		1 Burtal 2 Cremation 3 Removal from State Object Crematory or other (Specify) 21. SIGNATURE OF PINERAL SERVICE LICEMBEE 22. NAME AND ABORESS (8/2/9- Hebutus Md
death. e funera		Place adams fore the Edman	Ason Ave Botto Massage
nours af ed in by or remo		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, ahock, or heart failure. Liat only one cause on each line. IMMEDIATE CAUSE (Final	Interval Batween
within pletely cremati		disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF):	Metaslasis = 14eay
execu execu n and to bun	CATION	Sequentially list conditions, If any, leading to immediate b. DUE TO (OR AS A CONSEQUENCE OF):	
certificate be ding physiciar hygiene prior rother trau	IFICA	cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated eventa C. DUE TO (OR AS A CONSEQUENCE OF):	
death death e atten tental tental to ury, o	CERTIFI	DATE II ON THE III	
Y and and Y	EDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause give	PERFORMED? 1 VES 2 NO 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH?
St. of	IAN: ME		1 YES 2 NO
COLINE THE LANGE CERTIFICATE HAS THE State Dept., or item 23	Sic	EXAMINER? 1 YES 2 VNO 1 Operation: 2 FB/Outpetlant 2 DOA 4 Name of Barrier	ence 8 🗆 Other (Specify)
NG PHYSIC fter this cer sath with th	ву рну		28d. DEŞCRIBE HOW INJURY OCCURED
TTENDII TTOR: A after de		3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, tarm, street, fectory, offica building, stc. (Specify)	261. LOCATION (Street end Number or Rural Route Number, City or Town, State)
4 72 =	COMPLETE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and one) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at	
TO THE HOSPITAL TO THE FUNERAL De filed within 72 I	BE CC	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSI	
6 6 % X	7	30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	9011 Pruly 25 (77)
5		Suntil. P Kayani 2434 N Belvedere, 31. DATE FILED (MONTH), DBY, YOUT) 32. RECESTRAT'S GONATURE	and 19 mulitable 49 3 kg. 7.
		JUL 31 1995 July Mudser Karlett	



BALTIMORE, MARYLAND 21215-0020	ter death. Page 6 may be retained by the hospital or attending physici	the financial diseason name & change by detection for any and the latest and the state of the st
DIVISION OF VITAL RECORDS, P.O. BOX 68760	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be rotained by the hospital or attending physici	FERI DIRECTOR After this certificate has been signed by the attending obysician and completely filled in by the tuneral diseases a shall be advanted to the detailed the detailed the detailed to the control of the state of the
h-d	PITAL	FRAL

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IMPOR TO BE		30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CALL	SE DE DEATU	(ITEM 27) (T-	- Printl			2395			▶ 7/		
be filed within 72 hours a IMPORTANT: If Item 2	- 11	(Check only CERTIFYING PHY	ER: On the beet of					eath occure		ne, date e		d due to the	ceuse(e) a	and menner ee state Aonth, Day, Year)
ours after em 28 is LETED		3 Suicide 8 Could not be determined	building,	etc. (Specify)	At home, farm,			_		City o	TION (Street a Town, State)			ite Number,
mark v		1 Natural 5 Pending 2 Accident Investigation	(Month, D			JURY M	1 🗌 Y	RK?	NO					
d, or		27. MANNER OF DEATH	1 Inpatient 2	INJURY	28b. TII	4 Nursir	Bc. INJI	URY AT		_	(Specify)	NJURY OCCU	RED	
State Item		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		PLACE OF DEA	OTHER:								
Dept. of 23 she		DID TOBACCO USE CON	RIBUTE TO CA					UNC	ERTAIN					YES 2 NO
shows any										-	1 TYES 2	Х) ио	9	F DEATH?
	\$	PART II. Other significent condition	ne contributing to	deeth but r	not resulting	in the und	leriying	g ceuse g	iven in Pa		PERFOR	MED?	1	VERE AUTOPSY FIND WAILABLE PRIOR TO COMPLETION OF CAL
Injury, or	2		d											
other TIFIC		CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST	cDUE TO	(OR AS A CO	NSEQUENCE (OF):				_				1
traumatic	Sequentisity itst conditions, if sny, leeding to immediate cause. Enter UNDERLYING													
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5 E		interval Batwe IMMEDIATE CAUSE (Final												
or removal.	-	23. PART I. Enter the diseases, Dr	complications tha	at caused th	e deeth. Do			Fune						, Md.211
examiner		P R	P	0 1				D ADDRES		I.				wn Road
xaminer must be		1 XBuriel 2 Cremetton 3 Re 4 Donation 5 Other (Specify)		Garr	ison I	orest	Ve	t. Ce	em. 7	-31-	95 0	wings	Mil	ls, Md.
		204, METHOD OF DISPOSITION		20b. PL	ACE AND DATE	OF DISPOSIT	TION /Ne	me of		DATE	20c. LO	CATION - CI	tu or Tow	Md. 2113
notified TO RE		190. INFORMANT'S NAME (Type/Print) Shirley M. Tinkl	ar			o ADDRESS								MJ OTTO
E 18		John Emory Tin	kler, Sr.						ice C			aumame)		
once.	S S	9th 17. FATHER'S NAME (First, Middle, Last)			Plumber			18. MOTHER'S NAME (First,		E /First **		mbing		
	<u>.</u>	(Specify only highest grade Elementary/Secondary (0-12)			(Give kind of life. Do NOT	f work done du use retired.)	uring mo	st of working	g	160.			ভ। শ	
USE AS UPET		3 Widowed 4 Divorced 15. DECEDENT'S ED		Specify: White										
š .	- 16	11. MARITAL STATUS 1 Never Merried 2 X Merried	12. WAS DECEDEN FORCES? 1 IF YES, OIVE W	YES 2	NO If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) Black, White, etc.									
	NEK.	19 Brookbury Dr.		B					136				USA	
= 1	196	Md. Ba	ltimore			Reisterstown : 🗆 V						YES 2X N		
sage.	DIRECTO	10e. STATE 10b. COUN			10c, CI	TY, TOWN OF		11500	-				- 1	10d. INSIDE CITY LIMITS?
c , 2 , 3	HOL	Veterans Admin.	Medical C	enter		Pe	erry	Poi	nt			Ce	cil	
2, 3 should		9e. FACILITY NAME (If not institution, give				RS. MONTHS DAYS HOURS MIN. Aug. 27,1913 Mar. 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA					yland ATH			
		4. SOCIAL SECURITY NUMBER 218-03-0912	5. SEX	8. AGE (In yo	rs. last birthday; YRS.	MONTHS	YEAR DAYS	IF UNDER	MIN.	7. DATE (Dey, Ther)	12	Country)	
- 1	John Emory Tinkler, Jr. July 27, 1995										1995	YEAR	10:45PM	
		- 1												



		FOR STATE REGISTRAR	STATE OF MARYL		RITMENT OF H		MENTAL HYGIE				٩
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH MONTH	DAY YE	3. TI	IME OF DEATH	
		Frederick Milton					July 28		^~	4:45A	М
Pr		4. SOCIAL SECURITY NUMBER 218-28-1304	1 № M 2 🗆 F 63	(In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) April 6,	1932 V	ountry) 7irgi:	E (State or Foreign	,
. 2, 3 should	DIRECTOR	9a. FACILITY NAME (If not institution, give st Perry Point VAMC			Perry I	on location of di Point	EATH	Cecil		nty	
	띱	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. Cl	TY, TOWN OR LOCAT	ION			10d.	INSIDE CITY	
permit. Pages 1,		Maryland Balti	more	Ва	Ltimore C	County COOE	10g. CITIZEN	LIMITS? YES 2 NO			
	RA	2010 Longview Co	urt		101	21237			S.A.	COUNTRY?	
21215-0020 al or attending physician. for use as the burlat-transit	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 X YES IF YES, GIVE WAR OR DO	2 NO ATES	If yes, sp	ENDENT OF HISPAI	NIC ORIGIN? (Specify) in, Puarlo Rican, atc.) y:	Yea or No — 14.		merican Indian, ita, etc.	
r attending use as the	ED	15. DECEDENT'S EDUC	$\frac{11/4/52 - 11}{24710N}$		USUAL OCCUPATION	DN .	16b. KIND OF B	USINESS/INDUST			_
for a for	COMPLETE	(Specify only highest grade Elementary/Secondary (0-12) 12th Grade	completed) College (1-4 or 5 +)	(Give kind of life. Do NOT of Sales	work done during mo	st of working		cance Co		V	
The hos detach	MO	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maide				
YL de d	BE C	Frederick Milton	Tinsley, Sr	·			et F.A. Ch				
	10	190. INFORMANT'S NAME (Type/Print) Frederick Steven	Tinsley				Route Number, City or To Baltimore			1237	
ORE, e 6 may be rector, page		20a. METHOD OF DISPOSITION 1 (XBurla) 2 Cremation 3 Ramo	oval from Stata con		of disposition (Na		OATE 20c. 1	LOCATION - CHY	or Town, S	iteta	
Page (4 Donation 5 Other (Specify)		CITT2OII .	22, NAME AN	ID ADDRESS OF FA	CILITY				
BALTIMORE, after death. Page 6 may be by the funeral director, page moval.		Destay 9	John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 2120								
		23. PART i. Enter the diseases, or o	complications that cause	the death. Do	not enter the mo	da of dying, auc	h as cardiec or res	piratory arrest		Approximate interval Between	
		iMMEDIATE CAUSE (Final disease or condition	Pneumonia		/14/95					Onset and De	
within 24 mpletely fille cremation, went, the		resulting in death)	B	CONSEQUENCE (<u> </u>						
OX 68760 e be executed within 24 sician and completely filly innor to burial, cremation.	NOI	Sequentielly list conditions, if any, leeding to immediate	DUE TO (OR AS /	CONSEQUENCE (OF):						
	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury	OUE TO (OR AS /	A CONSEQUENCE ()F)·						
P.O. h certification and ing	ERTI	that initiated events resulting in death) LAST	1								
RDS, P at the death by the atten and Mental P y Injury, or	CAL C	PART II. Other aignificent condition	e contributing to deeth b	out not resulting	In the undarlying	g ceuse given in		AN AUTOPSY		E AUTOPSY FINOIN	VGS
K # 8 8 >	OIC.						1 TES	ORMED?	COM	LABLE PRIOR TO IPLETION OF CAUS DEATH?	E
L RECOlaw requires that as been signed tept, of Health as 23 shows an	MEDIC									YES 2 NO	
AL RE le law reque has been Dept. of a 23 sho	N.	DID TOBACCO USE CONTI				UNCERTAI	N 🗆				
를 하는 그	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO	HOSPITAL:		OTHER:						_
1. O o =	HYS	27. MANNER OF OEATH	1 Inpatient 2 ☐ ER/Outs 28a. DATE OF INJURY	28b. TI	ME OF 28c. INJ	URY AT	a Other (Specify) 26d. OESCRIBE HOY	V INJURY OCCUR	ED		
ON OF DING PHYSIC After this ce death with th	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		M 1 🗆 1	PRK? YES 2 NO					
ISIC TTEND TOR: A after d	0	3 Suicide a Could not be building, atc. (Specify) - At home, farm, street, factory, office 28t. LOCATION (Street and Number or Rural Route Numbi building, atc. (Specify)								Number,	
DIV TAL DR A AL DIREC 72 hours 11 item	COMPLETE	ngel -	CIAN: To the best of my know								
HDSPITAL FUNERAL Within 72 TANT: If	00	2 MEDICAL EXAMINE	R: On the basis of examination	n and/or investigat	ion, in my opinion, d						d.
B 등 등 등 등	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	7			29c. LICENSE NU D32395	MBER	29d. DATE SI	(Mon) (28/9)		
₽₽₩ ≦	2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	EATH (ITEM 27) (Typ	e, Print)	DJ2J3J		1 . //	20/).		
lita		THOMAS FINUCAN,			OINT, PER	RY POINT	, MD 219	02			
_ '		31. DATE FILED (Month, Day, Year)	32 REGISTRAR'S COM	Hall.							

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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH YEAR Maude Gertrude Vogt July 1995 5:45 A. 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign DAYS 220-44-0226 1 - M 2 -F 95 Aug. 25,1899 Maryland use as the bunal-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Augsburg Lutheran Home DIRECTOR Lochearn Baltimore RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Baltimore 1 TES 2 NO FUNERAL 10e. STREET AND NUMBER tor, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6811 Campfield Road 21207 U.S.A. hours after death. Page 6 may be refained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-tran WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—II yes, specify Cuban, Mexican, Puerto Rican, etc.)

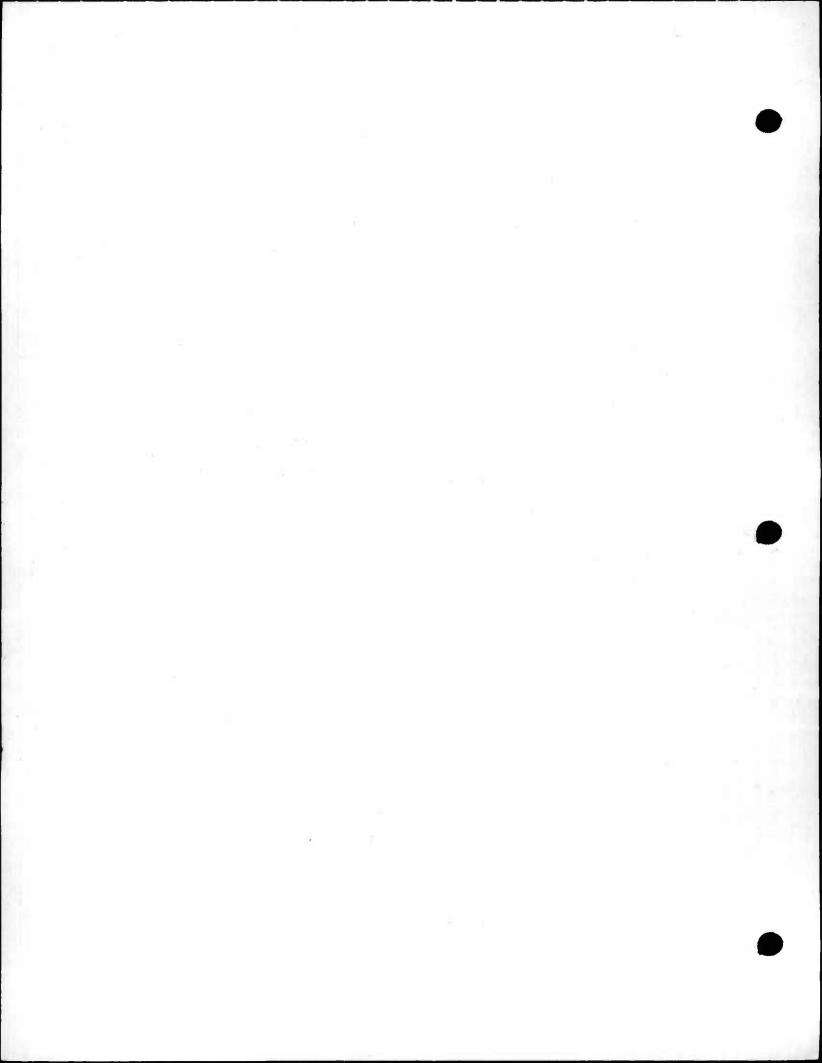
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY Specify: 3 Widowed 4X Divorced White 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Henry William Voqt F Annie Romoser BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Sheri Conklin Oak Forest Avenue Catonsville, Maryland 21228 ě 20a. METHOD OF DISPOSITION

1 M Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Woodlawn Cemetery July 31,1995 4 Donation 5 Other (Specify) Woodlawn, Maryland medical examiner 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes 10 this certificate has been signed by the attending physician and completely filled in by the twith the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. 1630 Edmondson Avenue Catonsville, Maryland 23. PART i. Entar the diseases or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrest, Approximate ahock, or heart fellure. List only one ceuse on each line interval Batween **IMMEDIATE CAUSE (Final** Onset and Death event, the disease or condition_ executed with Cerebral thrombosis 2 weeks resulting in death) DUE TO (OR AS A CONSEQUENCE OF): other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART ii. Other significent conditions contributing to death but not reaulting in the underlying cause given in Part i. the 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? law requires that any Colon carcinoma 1 YES 2 NO shows a atrial Fibrillation Chronic 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🗷 UNCERTAIN 🗆 PHYSICIAN: Dept. 23 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: PHYSICIAN: 1 TES 2 NO 1 - Inpatient 2 - ER/Outpatient 3 - DOA Nursing Home 5 Residence 8 Other (Specify) 5 27. MANNER OF DEATH 28b. TIME OF INJURY 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY After 2 Accident Investigation DR ATTENDING 28e. PLACE OF INJURY — At home, farm, atreet, factory, offica building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is COMPLETED 8 Could not be DIRECTOR: / 4 Homicide ltem. 29a. CERTIFIER
(Check only one)

CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(a) and menner as stated, one)

MEDICAL EXAMINER: On the best of examination and/or investigation in my celebral disth occurred at the time, date and place, and due to the cause(a) and menner as stated. TO THE HOSPITAL D
TO THE FUNERAL D
Se filed within 72 ho 2 ___ MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 7/31/95 D37573 5 30. NAME AND ADDRESS OF PERSON WHO COM LETTE CAUSE OF DEATH (ITEM 27) (Type, Print) Battimore MD Jef 7220 31. DATE FILED (Month, Day, Year)

JUL 31 1995

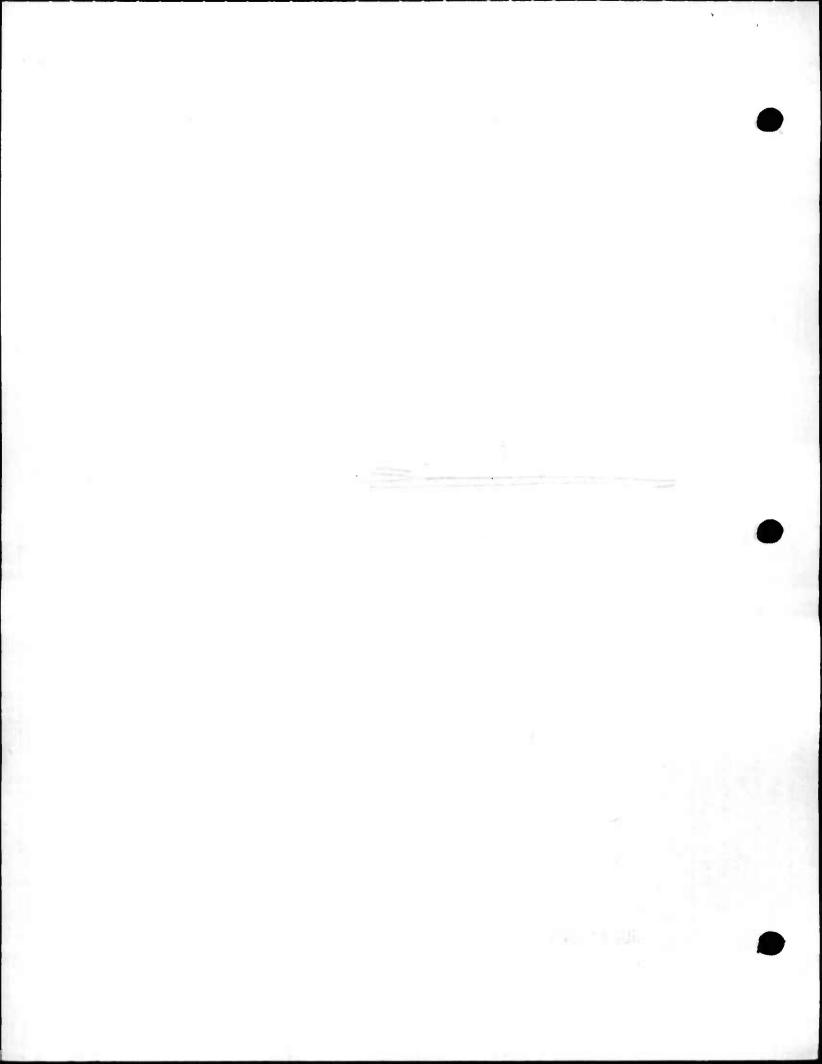


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DIVISION OF VITAL RECORDS, P.O. BOX 68760	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with
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_	OCDITAL

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 99 5 AR homas WILLIAMS 901 JULY D 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign JUN. 5, 1 224-05-8837 DAYS 1 X X 2 - F 77 VÍRGINIA 1918 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 96. CITY, TOWN OR LOCALLE BALTIMORE TOWN OR LOCATION 9c. COUNTY OF DEATH CHURCH HOME HOSPITAL DIRECTOR n/a RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND n/a BALTIMORE YES 2 NO use as the burial-transit permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3126 CLIFTMONT **AVENUE** 21213 STATES UNITED death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 € NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NAO Specify: 14. RACE — American Indian, Black, White, stc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married В 3 Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ğ Elementary/Secondary (0-12) College (1-4 or 5+) detached 5 TH LABORER CONSTRUCTION once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme) **THOMAS** THREATH WILLIAMS funeral director, page 5 should be notified at ROSA BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ROSA SCOTT SOUTH WEST ST., PETERSBURG, VA 641 23803 Pe 20e. METHOD OF DISPOSITION

VX Burial 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of must One there DUNDALK, 4 ☐ Donetion 5 ☐ Other (Specify) 8medicai examiner 21. SIGNATURE OF FUNERAL SERVICE LICEN 21202 filled in by the 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximata shock, or heart tallure. List only one cause on each line. ö Intarval Between IMMEDIATE CAUSE (Fine) Onset and Death the cremation, disease or condition DUE TO (OR AS A CONSEQUENCE OF): completely 0 resulting in death) traumatic event, and com o burial, Respiratory fe CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) prior to if any, leeding to immediate cause. Enter UNDERLYING mening 20 other t CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events attending resulting in death) LAST 6 the atten Mental F injury, PART II. Other algniticent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS and Wanic Rena Frime AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any PERFORMED? Signed Health a 1 TYES 2 NO Shows Hypereusion 1 YES 2 pt. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem State certificate **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 the 27. MANNER OF DEATH 28e. DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, with this Natural 2 Accident (Month, Day, Year) INJURY 5 Pending After ti BY 1 YES 2 NO Investigation 3 Suicide 28e. PLACE OF INJURY — At home, larm, street, fectory, office building, atc. (Specify) 28 is 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be DIRECTOR: hours after 4 Homicide If item 29a. CERTIFIER (Check only one) 1 DEERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner es stated. FUNERAL I basis of examination and/or investigation, in my opinion, death occurad at the time, date end pieca, end due to the cause(e) end menner ee stated. IMPORTANT: 296. SIGNATURE AND TITLE OF CERTIFIE THE F BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 4334 28/ 95 2 2 3 w wo 2 30. NAME AND ADDRESS OF PERSON WHO LETED CAUSE OF PEATH (LTEM 27) (Type, Print) 1 Men b90119 31. DATE FILED (Month, Day, Year) Jahr Wheeler hardell 31



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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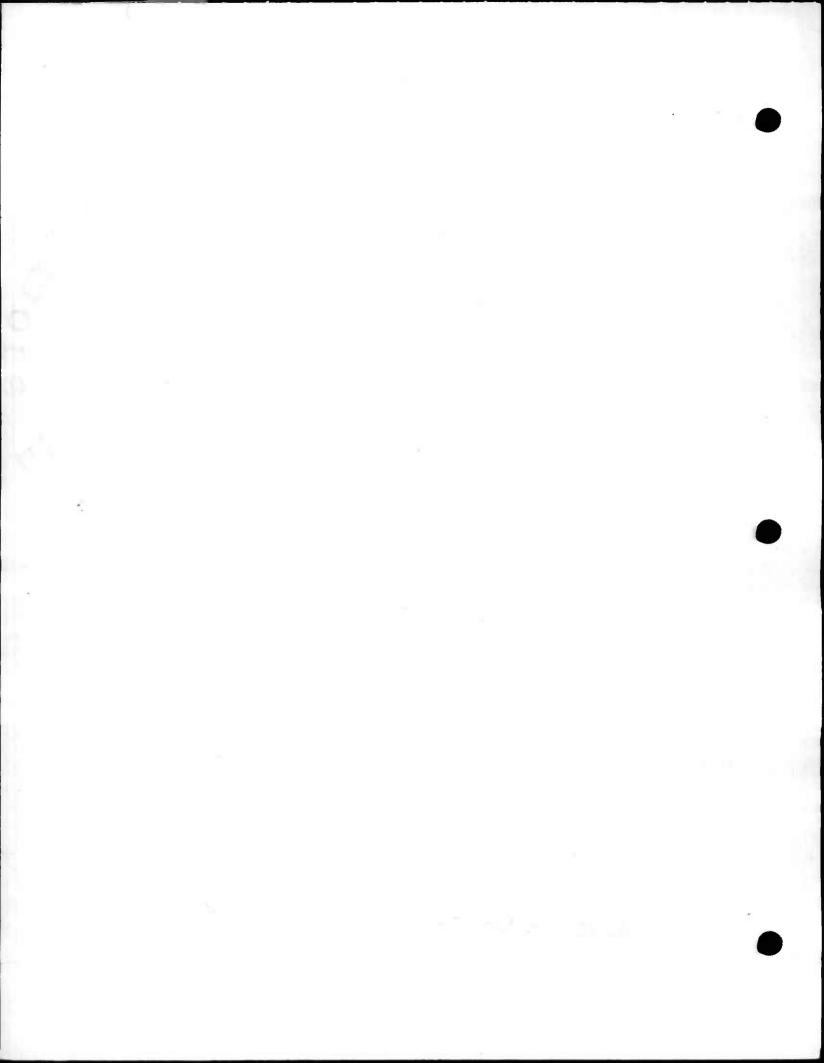
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF CEATH 3. TIME OF DEATH 29 1995 Mary 7:40 WATSON July Ам 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 5-20-06 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 217-20-0898 1 M 2 F 89 VA Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR Franklin Square Hospital Essex Baltimore County 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY n/a BALTIMORE Baltimore DUNDALK MD permit. 1 Tyes 2 NO FUNERAL 10a STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burlal-transit 31 Oak 21222 USA hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-It yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. Specify: black BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO 1 Never Married 2 Merried It yes, specify Cuber
1 YES X NO BY Specify: 3 Widowed 4 Divorced COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complex) 16a, DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ive kind of work done Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) self employed grocery store + 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) T unk. Lucy Dean 띪 notified a 19b. MAILING ACORESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. INFORMANT'S NAME (Type/Print) 2 Charles Tyler pe 20e. METHOD OF OISPOSITION 20b. PLACE ANO DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must 1 ☑ Muriel 2 ☐ Cremetion 3 ☐ Removal from State Donation 5 Other (Specify) Memorial Park 8/1 Arbutus Arbutus, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons Funeral Home Con 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

Approxima the medical filled in by Approximate ock, or heart failure. List only one ceuse on each line 0 Interval Betwe IMMEDIATE CAUSE (Finel Onset and Death the cremation. disease or condition signed by the attending physician and completely in Health and Mental Hygiene prior to burial, crematic reaulting in death) Pulmonary Edema event. 4 days OUE TO (OR AS A CONSEQUENCE OF): Congestive Heart Failure and Atrial Fibrilation 4 days traumatic CERTIFICATION Sequantially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediata cause. Enter UNDERLYING requires that the death certificate be CAUSE (Disease or Injury other that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST 0 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMEO? Pyuria (urinary Tract Infection) any 1 TYES 2 NO shows a DE DEATH? Hyponutremia upon admission 1 YES 2 NO t, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO I UNCERTAIN PHYSICIAN: has b. Dept. The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h item HOSPITAL:
1 Minpetient 2 ER/Outpetient 3 L OR ATTENDING PHYSICIAN: Th L DIRECTOR: After this certificate 2 hours after death with the State OTHER: 1 YES 2 K NO DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural 5 Pending M 1 YES 2 NO ΒY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, tectory, office building, etc. (Specify) 3 Sulcide 40 ETED. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 28 Item 29e. CERTIFIER COMPL CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. E FUNERAL D TO THE HOSPITAL
TO THE FUNERAL I
BE filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner ee stated. 29b. SIGNATURE AND PITLE OF CERTIFIED 29c. LICENSE NUMBER 46 BE 29d. DATE SIGNED (Month, Day, Year) 129/95 nale 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Acorn Circle #102 Baltimore Md. 21206 MD 45 Koroush Khalighi 32. APGISTRAD'S SIGNATURE

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH AEG NO 2. DATE OF DEATH DAY JULY 28, 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 1995 YEAR Wilson Walter 03:04A 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (in yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 9. BIRTHPLACE (State or Foreign 219-16-8150 DAYS 1 1 1 2 | F 69 YRS. 3-14-26 executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH THE JOHNS HOPKINS HOSPITAL DIRECTOR BALTIMORE CITY n/a RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Elkridge Baltimore 1 TES TONO FUNERAL 10. STREET AND MUMBER 10g, CITIZEN OF WHAT COUNTRY? 6077 Meadow Ridge Rd. 21227 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1. YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yee, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE - American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried 1 TES 3/ NO ₩ Specify 3 Widowed 4 Divorced Black WWI ED 15. OECEDENT'S EOUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b. KINO OF BUSINESS/INOUSTRY COMPLET Elementery/Secondary (0-12) College (1-4 or 5+) 6th Laborer Construction once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme) notified at Richard Wilson, Isabel<u>le Henson</u> BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Richard Wilson, 6048 Meadow Ridge Rd. Elkridge, MD 2122 pe 20e. METHOO OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1 Donation 5 Other (Specify) kridge Independent Cem. Elkridge, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons Funeral Home 1701 Laurens St. completely filled in by the ial. cremation, or removal. Balto. Md 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cerdiec or respiretory arrest, other traumatic event, the medical shock, or heart fellure. List only one ceuse on each line Intervel Batween **IMMEDIATE CAUSE (Fine)** Onset and Daath disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): burial, Veno Deep weeks CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING physician pe requires that the death certificate CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events attending resulting in death) LAST injury, or Mental the PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE een signed by the PERFORMED? shows any 1 YES 2 | NO OF DEATH? 1 TES 2 NO peen DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN V PHYSICIAN: Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL DR ATTENDING PHYSICIAN: The 28. PLACE OF DEATH (Check only one) item this certificate h with the State I HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) marked, or 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending investigation 1 YES 2 NO DIRECTOR: After the hours after death v BΥ 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 22 6 Could not be COMPLETED 4 Homicide 28 determined item 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. TO THE FUNERAL (
TO THE FUNERAL (
DE filed within 72 h
IMPORTANT; If if (Check only one) HDSPITAL 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and menner es stated. 29b. SIGNATURE AND TITLE OF CERT BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) alust 95 TO523 28 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MALCOLM BROCK 600 N. WOLFE STREET BALTIMORE, MARYLAND 21287 31. DATE FILED (Month, Day, Year)

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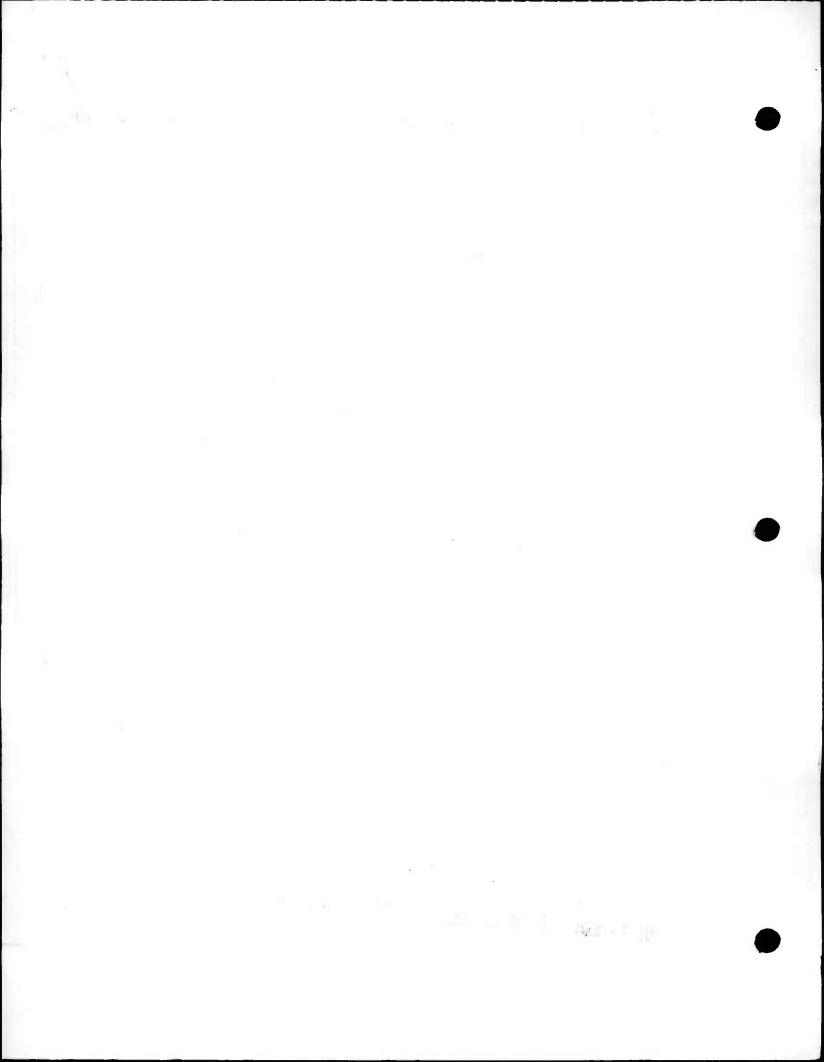


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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

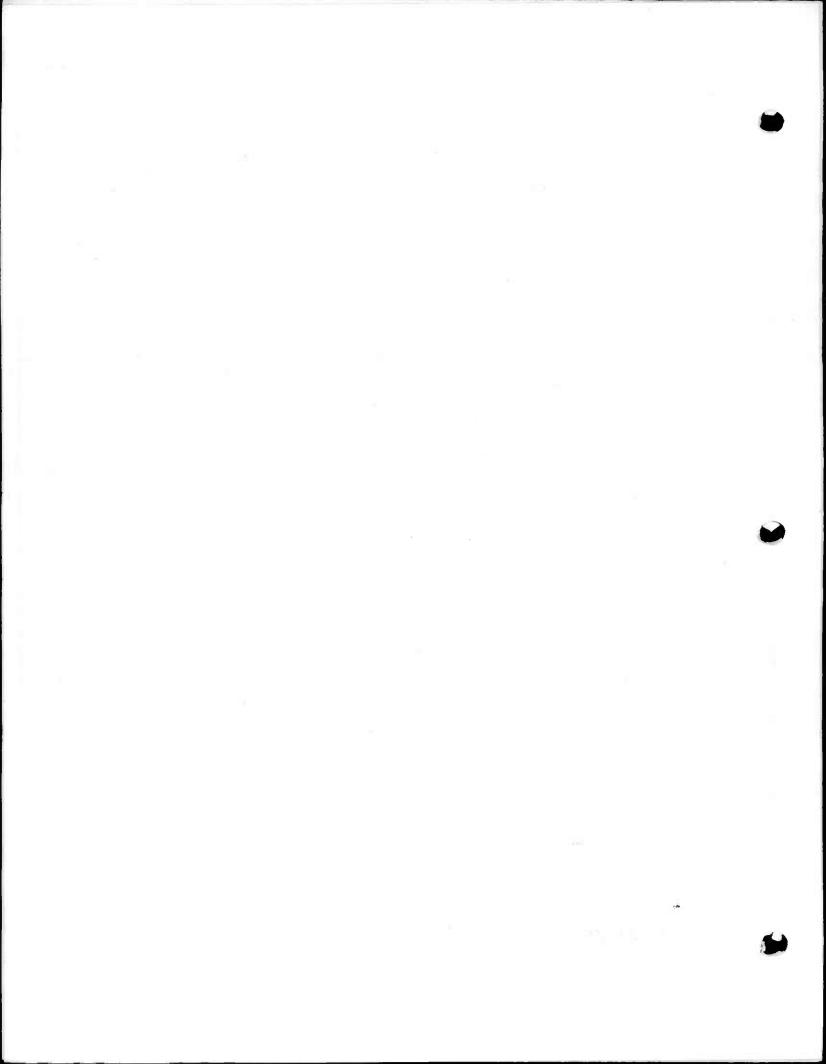
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		1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
		1. DECEDENT'S NAME (First, Middle, Last)	Wright	ht			2. DATE OF DEAT	H DAY	ZEAR 240 AM M
	PLETED BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 5. SEX 218-42-5670 1 - 10	6. AGE (In yrs. In		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTY (Month, Day, Yo	1	BIRTHPLACE (State or Foreign Country)
		9a. FACILITY NAME (If not institution, give street and	number)	96.	. CITY, TOWN O	OR LOCATION OF DE		9c. COUNT	Y OF DEATH
		RESIDENCE OF DECEDENT	Care		pal	to		1 10	IA
		Md Bal	to	10c. CITY, TO	Sa.	(to			10d, INSIDE CITY LIMITS? 1 YES 2 NO
		2/02 DIVISION	st.		101	2121	7	109. CITIZE	N OF WHAT COUNTRY?
		1 Never Married 2 Married FOR	S DECEDENT EVER IN U.S. AI RCES? 1 1 YES 2 YES, GIVE WAR OR DATES	RMED NO	If yea, sp		NIC ORIGIN? (Specifien, Puerto Rican, atd y:		I. RACE — American Indian, Black, White etc. Specify: Diac C
		15. DECEDENT'S EDUCATION (Specify only highest grade complete Elementary/Secondary (0-12) Colleg	d) (C	Give kind of work	done during mo tired.)	ON st of working	16b. KIND O	Ret.	al
be notified at once.	E COMPL	17. FATHER'S NAME (First, Middle, (ast))	ishington			18. MOTHER'S NA	ME (First, Middle, M.	eiden Surname	iks
notified	TO B	In informant's NAME (Type/Print)	Jr. 19	96. MAILING ADD	DRESS (Street a	nd Number or Rural	Route Number, City o	to, Me	A Dining
		20a_METHOD OF DISPOSITION 1 & Burlet 2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify) Date Dat							
or removal. medical examiner must		21. SIGNATURE OF FUNERAL SERVICE LICENSES	. Lat		22. NAME AN	D ADDRESS OF FA	uneral 1	ome - W	lest
removal		23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between							
		intervel Between IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Pul monary Sarcoldosis [6 4R5]							
event, the	NOIL	resulting in death)	DUE TO (OR AS A CONSE	OVERICE OF):	MI'C	01005	15		16 yrs
matic		Sequentially list conditions, if any, leeding to immediate	DUE TO (OR AS A CONSE	OUENCE OF):					
her trau	RTIFICATION	ceuse, Enter UNDERLYING CAUSE (Disease or injury thet initieted events	DUE TO (OR AS A CONSE	OUENCE OF):					
tal Hygiene	ші	resulting in death) LAST							
and Mental y Injury, o	SAL C	PART ii. Other significent conditions contri	buting to deeth but not	resulting in th	ne underlying	ceuse given in	Pert i. 24a. WA	S AN AUTOPSY RFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
shows any in	MEDICAL						1 🗆 YE	S 2 NO	OF DEATH? 1 YES 2 NO
3 ed	AN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)							
or item 23	SICI	EXAMINER? HOSP		ОТ	HER:	s 5 🗆 Residence	ax Other (Specify	Sub-ac	ite Facility
ked,	COMPLETED BY PHY	27. MANNER OF DEATH 1 Netural 5 Pending	a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJ WO	URY AT RK?		OW INJURY OCCUP	
after death		2 Accident Investigation 3 Suicide 8 Could not be determined determined				ES 2 NO	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
ten i		29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and menner as stated.							
PORTANT: If I		29b. SIGNATURE AND TITLE DF CERTIFIER							
De tiled within	O BE	4	x 2	<u></u>		29c. LICENSE NUM	ABER 573	29d. DATE S	19 (Month, Day, Year)
	ř	30. NAME AND ADDRESS OF PERSON WHO COMPL	ETED CAUSE OF DEATH (ITE	M 27) (Type, Print	~	1. 11	T V	0-11	115-7



DIVISION OF VITAL RECORDS, P.O. BOX 13146,	BALTIMORE, MARYLAND 21203-3146
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	PHYSICIAN: The law requires that the death certificate be executed within yours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete the bythe it be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burlal, cremation, or removal.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete to the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)	M. WI	1. Whitcomb			2. DATE OF DEAT MONTH	28 194	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 213-20-3747	1 🗆 M 2 💢 F	(In yrs. last birthday)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year Aug. 17	,1897	BIRTHPLACE (State or Foreign Country) Maryland	
TOR	90. FACILITY NAME (If not institution, give street and number) Chapel Hill Nursing Center RESIDENCE OF DECEDENT			96. CITY, TOWN OR LOCATION OF DEATH Randallstown			%. COUNTY OF DEATH Baltimore		
DIRECTOR	106. STATE 106. COUNTY Md. Baltimore		10c. CIT	Owings MIls			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XNO		
FUNERAL	100. STREET AND NUMBER 12516 Park Hei		101. ZIP CODE 21117				N OF WHAT COUNTRY? JSA		
B≺	11. MARITAL STATUS 1 Never Married 2 Merried 3 Never Married 4 Divorced 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D.		S 2 XNO	2 XNO If yes, specify Cuben, Maxican, P.			orto Ricen, etc.) Black, White, etc. Specify: White		
COMPLETED	(Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4 or 5 +)			(Give kind of work done during most of working life. Do NOT use retired.)			b. KIND OF BUSINESS/INDUSTRY		
MP	12			Housewife			Own home		
	17. FATHER'S NAME (First, Middle, Last) Richard Tillman			18. MOTHER'S NAME (First, Middle, Maiden Sumarn Emma Johnson					
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	nd Number or Rural I		Town, State, Zip C	ode)	
유	Royland R. Whitco	mb							
	Royland R. Whitcomb 12516 Park Heights Ave. Owings Mills, Md. 21117 20a. METHOD OF DISPOSITION 1 Burlet 2 Keremetion 3 Removal trom State 4 Donetion 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cametery, crematory or other place) Carroll Cremation 7-28-95 Hampstead, Md.							ty or Town, State	
	21. SIGNATURE OF FUNERAL SERVICE LICENSE Decel 22. NAME AND ADDRESS OF FACILITY 11824 Reisterstown Road Eline Funeral Home Reisterstown, Md. 21136								
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, euch as cardiec or reepiratory arrest, shock, or heart failure. Liet only one cause on each lina. IMMEDIATE CAUSE (Final disease or condition resulting in death) Out To 1919 AS A CONSEQUENCE OF):								
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that infilteded events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
MEDICAL C	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PERFORMED? 1 YES 2 NO 24b. WERE AU ANLABLE COMPLET OF DEATH							24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	ACE OF DEATH (Ch	eck only one)			
14S	1 TYES 2 THO 27. MANNER OF DEATH	1 Inpatient 2 ER/O	· .	4. Nursing Hom	ne 5 🗆 Reeldence			000	
	1 Natural 5 Pending	(Month, Day, Year		IURY WO	YES 2 NO	280. DESCRIBE H	OW INJURY OCCUI	RED	
red BY	2 Accident Inventigation 3 Suicida 8 Could not be 4 Homicide determined	RY — At home, term, pecify)			281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated.								
ECC	29b. SIGNATURE AND TITLE OF CERTIFIE		29c. LICENSE NUI		29d. DATE SIGNED (Month, Day, Year)				
O BE	Da 6 Dy de			206982			1 7/28/91		
۲	Dr. David Miller 10219 S. Dolfield Rd. Owings MIls, Md. 21117								
	31. DATE FILED (Month, Day, Year) JUL 31 1995	SE RECHSTRAR'S OF				<u> </u>			





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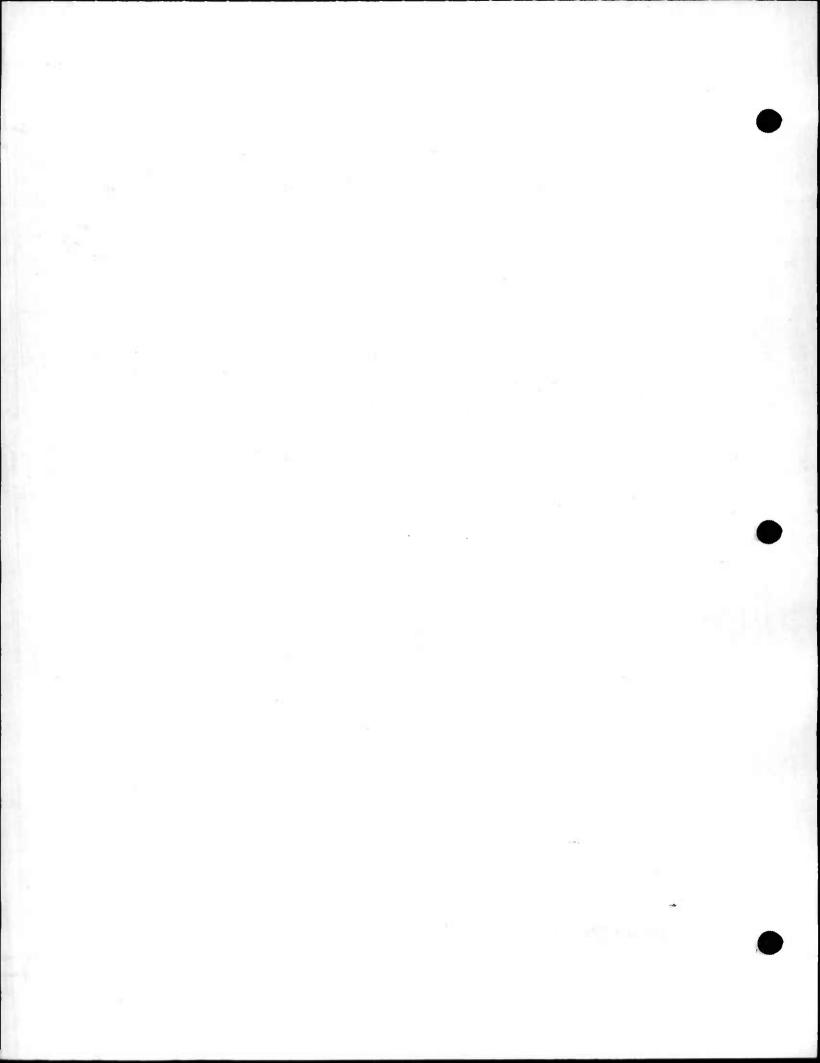
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DIVISION OF VITAL RECORDS, P.O. BOX 6876	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH EUGENE Paul 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 5. SEX 6. AGE (In vrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State of Foreign (Month, Day, Year) eb. 24,1937 190-28-5332 58 1 X M 2 - F Feb. Pennsylvania 9e. FACILITY NAME (If not institution, give street end number 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Saint Joseph Medical Center Towson, Maryland Baltimore RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Catonsville 1 - YES 2 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1038 Lakemont Road 21228 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yes, specify Cuben, Mexicen, Puerto Rican, atc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES ВY Specify: 3 Widowed 4 Divorced White 1954 - 1958 COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Engineering Technician Department Of Defense once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Eugene H. Young Mary Ellen Steinhiser BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Rita Young 1038 Lakemont Road Catonsville, Maryland 21228 pe 20b. PLACE AND DATE OF DISPOSITION (Name of July 31 20e. METHOD OF DISPOSITION 20c. LOCATION - City or Town, State must 1995 2☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Owings Mills, Maryland event, the medical examiner 21. SIGNATURE OF SUPERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes eller 1630 Edmondson Avenue Catonsville, Maryland 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line cremation, or Interval Batween IMMEDIATE CAUSE (Final Onset and Daath disease or condition been signed by the attending physician and completely xt. of Health and Mental Hygiene prior to burial, cremativ . MYOCARDIAL INFARCTION reaulting in death) 2 HOURS DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other OUE TO (OR AS A CONSEQUENCE OF): that initieted events reaulting in death) LAST 6 Injury, PART II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 24s. WAS AN AUTOPSY PERFORMED? shows any 1 TYES 2 NO 1 WES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. r this certificate has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO 4 - Nursing Home 5 - Residence 6 - Other (Specify) 0 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked. Natural 5 Pending 1 YES 2 NO BY THE FUNERAL DIRECTOR: After filed within 72 hours after death 2 Accident 3 Sulcide 26e. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 28 Is ED 8 Could not be 4 Homicide COMPLET item 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, end due to the cause(e) end menner es stated. = 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(a) and manner es stated. IMPORTANT 296- SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. OATE SIGNED (Month, Day, Year) 18 33 m 20000 carmen, 23 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS GUARNIERT M.D 6569 N. CHARLES ST. BALTIMORE 31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 3 1 1995 DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



DIVISION OF VITAL RECORDS, P.O. BOX 68760

FUNERAL

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MEDICAL CERTIFICATION

PHYSICIAN:

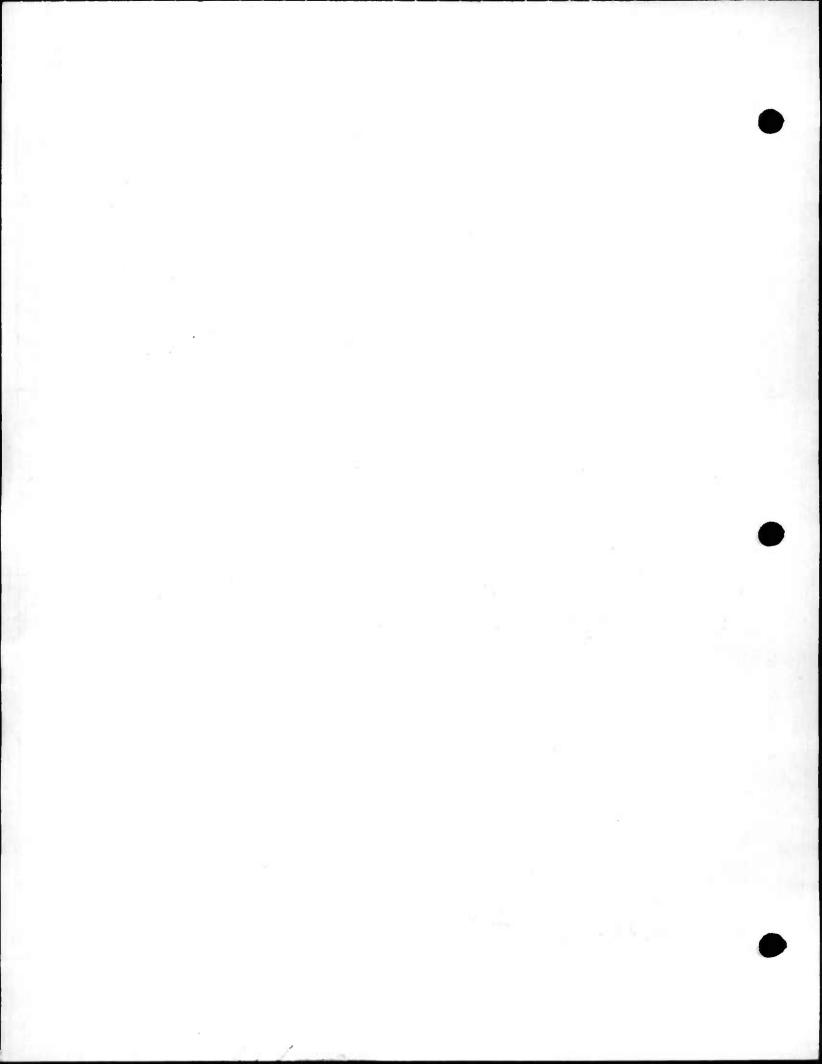
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23020 FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. OECEOENT'S NAME (First, Middle, Last 2. DATE OF DEATH 3. TIME OF DEATN George W. Yeager Jr. 28 July 1995 0437A. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 214-26-7105 1X M 2 🗆 F Dec. Maryland 65 25, 1929 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN DIRECTOR VA Medical Center BALTIMORE RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore City Baltimore 1 X YES 2 NO 10. STREET AND NUMBER 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 3620 Elm Avenue U.S.A. 21211 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 + YES 2 NO IF YES, GIVE WAN OR OATES 11 MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuban, Mexican, Puerlo Rican, etc.)
 \(\subseteq \text{YES 2 [X NO Specify:} \) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 X Married ВУ 3 Widowed 4 Divorced White Korea COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) Baltimore City Softball Coordinator 8 Department of Recreation 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) George W. Yeager, Sr. Mary Anna Wernick 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3620 Elm Avenue, Baltimore, Maryland Geraldine Yeager 21211 2ps. METNOD OF OISPOSITION
1A3 Burlel 2 Cremation 3 Removal from State
4 Donation 5 Otter (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Maryland Veterans Cemetery 18/2 Crownsville, Maryland 21. SIGNATURE OF JUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road. Baltimore, 23. PART I. Enter the diseases, or complication, that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition Ventricular Arrythmia resulting in death) DUE TO (OR AS A CONSEQUENCE OF) **ARDS** Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING Sepsis CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Multiple Organ Failure PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 1 TES 2 NO OTHER: Inpetient 2 - ER/Outpetient 3 - DOA 6 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCUREO 1 Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29a. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

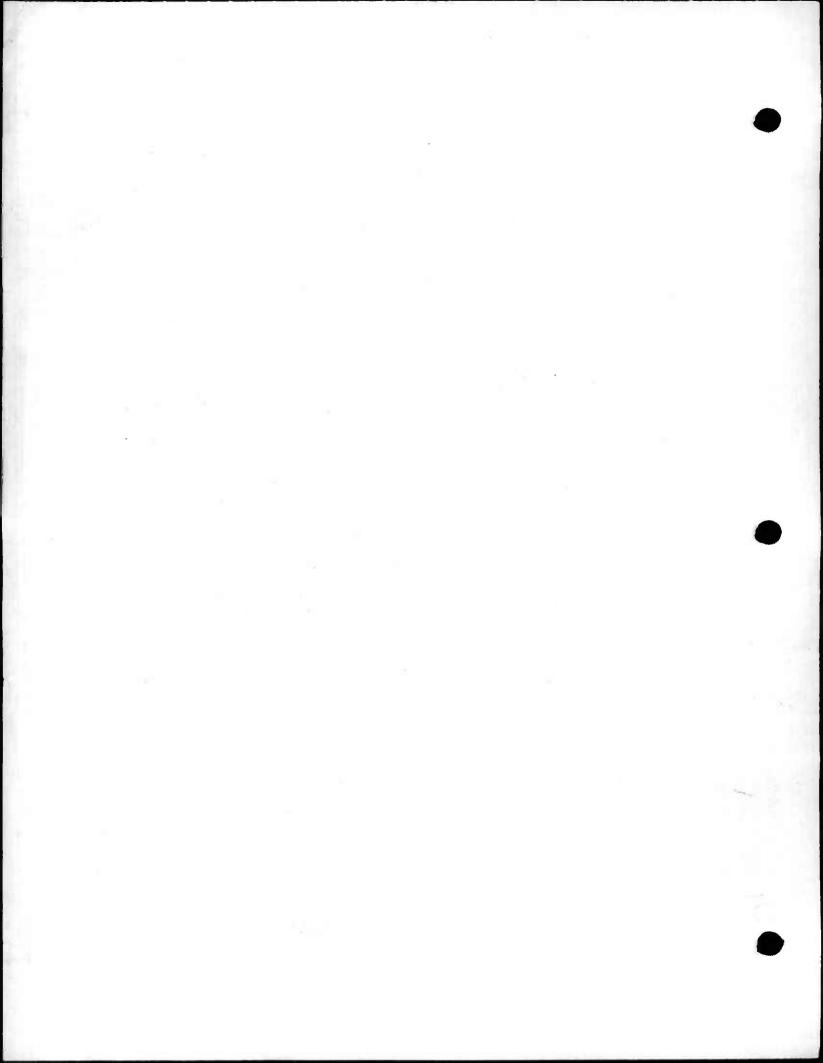
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 50685 PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print) 10N.



BALTIMORE, MARYLAND 21215-0020	PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be State Dept, of Health and Mental Hyglene prior to bunial, cremation, or removal.
OF VITAL RECORDS, P.O. BOX 68760	PHYSICIAN: The law requires that the death certificate be executed with 24 h	this certificate has been signed by the attending physician and completely fille with the State Dept. of Health and Mental Hygiene prior to burial, cremation,

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH BRUTON ELEMON 0549 AM SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER t YEAR IF IMDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year (Month, Day, Year 1 M 2 F DAYS 1937 . FACILITY NAME (If not institution, give street and nu 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Ba A DIRECTOR tospita RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a, STATE 10b COUNTY 10d. INSIDE CITY LIMITS? 20 YES 2 NO FUNERAL 10f. ZIP CODE 10e. STREET AND NUMBER WHAT COUNTRY? 10g. CITIZEN OF 21229 4200 ol borne 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White etc. Specify: Black 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES If yes, specify Cuben, Mexican, Pt

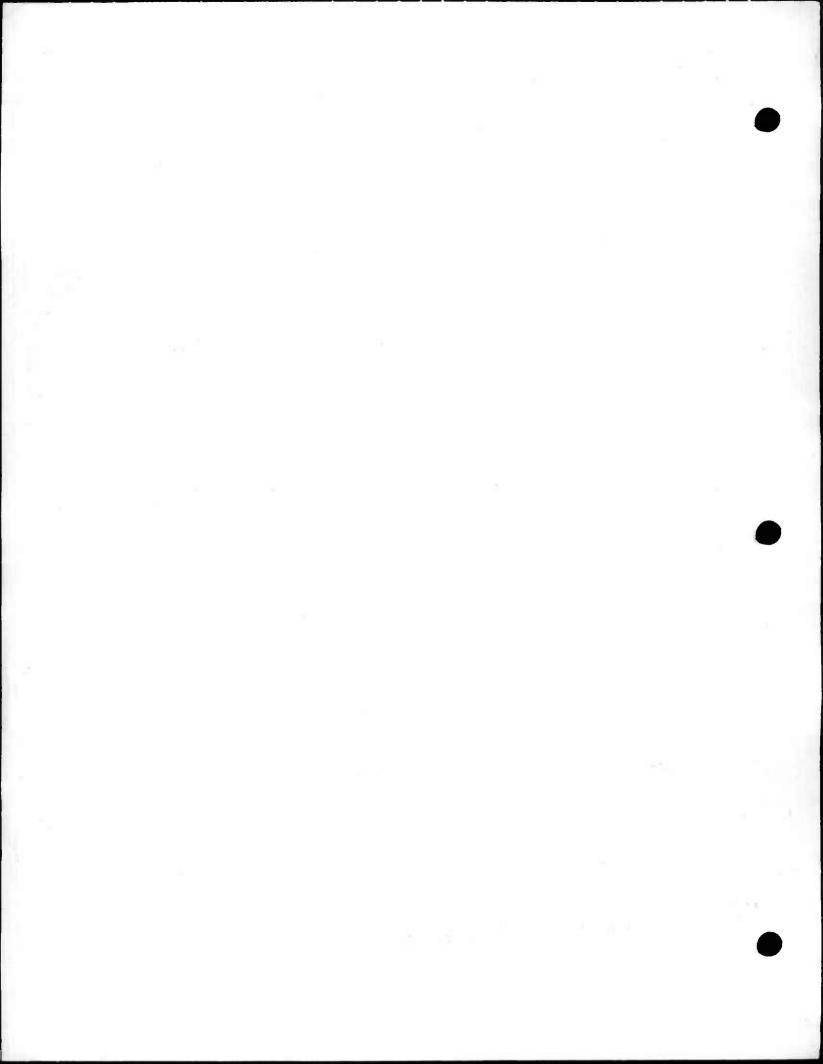
1 YES 2 NO Specify: Never Merried 2 Merried В 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during mest life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) ndary (0-12) Whit Taspita rector notified at once. TATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle D41 rede BE MANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Stre (s, Zip Code) 2 2020 21244 (to, ma ness pe METHOD OF DISPOSITION 295. NLACEAND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Buriel 2 Cremation 3 Removal from State OWING Mills, examiner 22. NAME AND ADDRESS OF FACILITY H-u bas -WeST +300 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory errest, ehock, or heert failure. List only one cause on each line. **Approximate** Interval Between Onset and Death **IMMEDIATE CAUSE (Final** the disease or condition MAGS KK5/1N00NY event, t resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF) traumatic - JULITIME Inson EMILVAL 2 wks CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediata cause. Enter UNDERLYING Anrenoscienone CAND. SUNSCULM YNS CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO Brownspina COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN IN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 27 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Reeldence 6 Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? marked, 28b. TIME OF INJURY 26d. DEŞCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO THE HOSPITAL OR ATTENDING POTHE FUNERAL DIRECTOR: After the filed within 72 hours after death v MPORTANT: If Item 28 is mart В 2 Accident 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. PLACE OF INJURY — At home, ferm, atraet, factory, office building, etc. (Specify) 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) end menner ea stated. 2 __ MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner ea stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Mgnth, Day, Year) E.P. I.MSLIM MO 021757 2 2 2 ₹ 155 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOME PURKY mil. WORTHULSS 1005 pm choken 31. DATE FILEO (Mo 32. REGISTRAR'S SIGNATURE AUG 0 1 1995



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or at	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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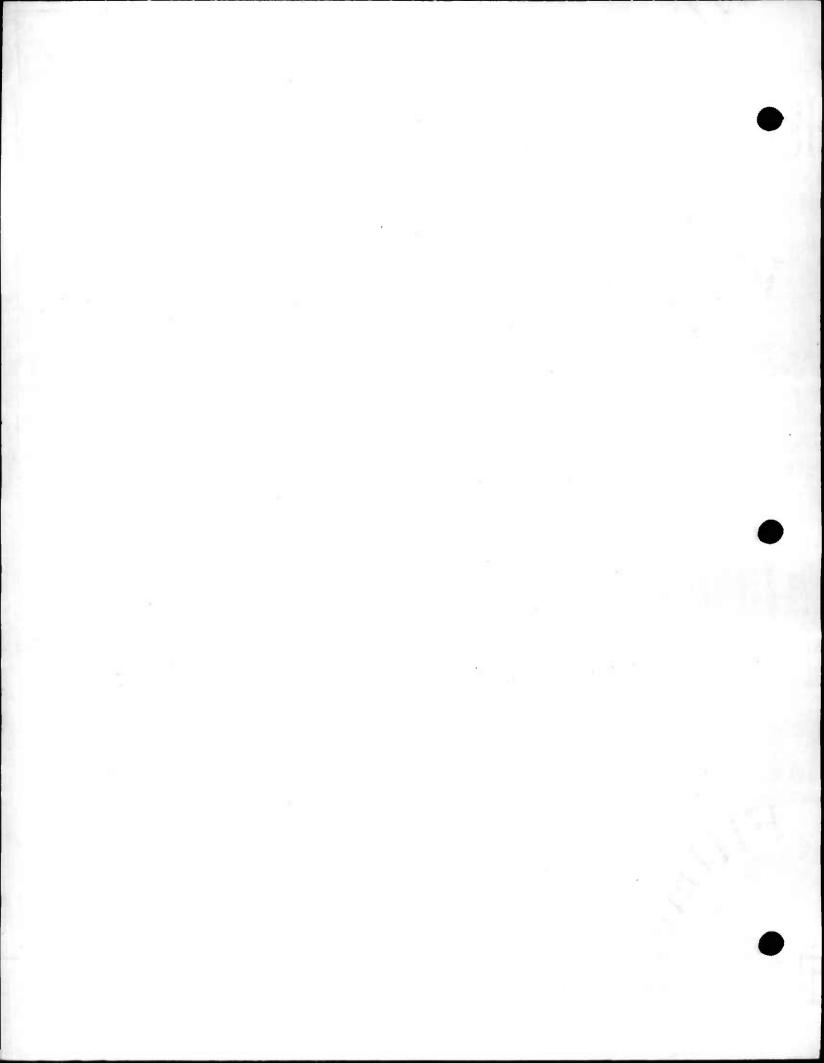
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 5.15 D ev 6. AGE (In yrs. lest birthday) 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH 8. BIRTNPLACE (Str -841 1 M 2 YRS. tending physician. as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, of 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR la RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY a 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER INF. ZIP CODE 10g. CITIZEN OF 806 21207 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 □ NO IF, YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 YES 2 NO BY Specify: 3 Widowed 4 Divorced Kuck ietnam LETED 15. DECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade complete entary/Secondary (0-12) College (1-4 or 5+) stranaul e COMP ab 17. FATNER'S NAME (First, Middle, Last) notified at BE 19s. INFORMANT'S NAME (Type/Print) 19h MAILING ADDRESS (Street Number, City or Town, State, Zip Code) ဥ be 20s, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of must l 20er LOCATION - City or DATE Burisi 2 - Cremetion 3 🗌 Ra Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY F. 2/2/1 medicai 23. PART I. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or respiretory erreat, Approximata ahock, or heart failure. Liet only one ceuse on each line interval Betwe IMMEDIATE CAUSE (Finel Onset and Daath the diseese or condition resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): other traumatic CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST Injury, or PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? PERFORMED? item 23 shows any tacosus 1 TYES NO NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) EXAMINER? HOSPITAL: 1 YES 2 NO 4 Nursing Home Residence 6 Other (Specify) Inpatient 2 - ER/Outpo 3 DOA 6 27. MANNER OF GEATH 26s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED marked, 1 Natural 1 YES 2 NO BY Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) MPORTANT: if item 28 is COMPLETED 4 Homicide 1 DECERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated. MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner ee stated. RE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



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		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY YEAR	3. TIME OF DEATH
		LESTER 4. SOCIAL SECURITY NUMBER	5, SEX 6, AGE		CHETT		Jul 27 1	995	7:10 pm
pin		218-09-7364	1 ¬M 2 □ F	(in yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS.		915 Vi	ATHPLACE (State or Foreign untry)
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Pages	DIRECTOR	Morey Lond Dollar			Y, TOWN OR LOCAT				10d. INSIDE CITY LIMITS?
permit.		Maryland Balti 100. STREET AND NUMBER	more County	Lut	herville	ZIP CODE		T 10c CITIZEN O	1 TES 2 TO NO
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21215-0020 al or attending physician. for use as the burial-transit	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	If yes, sp	ENDENT OF HISPA	NIC ORIGIN? (Specify Year, Puarto Rican, atc.) fy:	e or No— 14. R/BI	ACE — American Indian, ack, Whita, etc.
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YLAN by the hor be detach at once.		17. FATHER'S NAME (First, Middle, Last)	1				AME (First, Middle, Meiden		
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MAR e retained e 5 should notified		Mrs. Esther Barre	on				ve. Luther		
may be		20e-METHOD OF DISPOSITION 1 \(\text{\text{Durial}} \) 2 \(\text{Cremation} \) 3 \(\text{\text{Remotion}} \) Remotion		. PLACE AND DATE	OF DISPOSITION (Na	me of	DATE 20c. LO	CATION — City or	Town, Stata
		4 Donation 5 Other (Specify)	B	osley U.	<u>Meth Ch</u>		7/31 Spa	rks. Mar	vland
BALTIMOR hours after death. Page 6 ma ed in by the funeral director, p or removal. medical examiner must		Martin D. Laws	com			ell-Wied	efeld Home d. Baltimo		
within 24 within 24 npletely fill cremation, vent, the	1 1	IMMEDIATE CAUSE (Final	BILATERAL II	NFILTERAT	E	de of dying, auc	h as cerdiac or reep	ratory arrest,	Approximata Interval Between Onset and Death 3 DAYS
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ate ate	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	H (Check only one) OTHER:				
SICIAN: The certificate to the State	≥	1 TYES 2 NO 27. MANNER OF DEATH	1 Inpatiant 2 ER/Outp	patient 3 DOA 28b, TIM	4 Nursing Home		8 Other (Specify)		
F H S F	BY PI	1 Ratural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	M 1 Y	RK? 'ES 2 NO	28d. DESCRIBE HOW I	NJURY OCCURED	
TTEND TOR: A after d	8	3 Suicide 8 Could not be detarmined	28a. PLACE OF INJURY building, atc. (Spec	— At homa, farm, a	street, factory, office		281. LOCATION (Street a City or Town, State)	and Number or Rura	il Route Number,
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223	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (To-	Print	D41410		-10	27-95
6		JOGINDER P. MEHTA	4 M.D., 762	0 Yorl		id, B	Alto, m	D	
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FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN YEAR 05 PM WILLIAM BERNARD BRIDGES 7. DATE OF BIFTH (Month, Day, Year) 28 955 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BtRTHPLACE (State or Foreign Country) 218 36 9504 TITT. MARYL 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Pages 1, 2, 3 DIRECTOR STELLA MARIS HOSPICE TOWSON BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY toc. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/A BALTIMORE 1 X YES 2 NO permit. 10a. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit and Hygiene prior to burial, cremation, or removal. 4313 BELVIEU AVENUE 21215 OF A hours after death. Page 6 may be retained by the hospital or attending physician. 12. Was decedent even in u.s. armed forces? 1 A yes 2 \square no if yes, give war or dates 1961-196613. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—II yes, specify Cuben, Mexicen, Puerto Ricen, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried 3≤ 3 Widowed 4 Divorced BLACK COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12TH YEARS MD. STATE PENITENTIARY CORRECTION OFFICER 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) at WILLIAM LEE BRIDGES BE LILLIE ROUZIE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 MRS. ANN M. BRIDGES 2301 PENTLAND DRIVE BALTO., MD. 21234 pe 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 2/95 DATE 20c. LOCATION — City or Town, State must 20a. METNOD OF DISPOSITION

1 X Burlel 2 Cremation 3 Ren

4 Donation 5 Other (Specify) GARRISON FÖREST VET. CEM. OWINGS MILLS, MD.CO. GWYNN^{22.} NAME AND ADDRESS OF FACILITY examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lewis T. LEWIS T. GWYNN FUNERAL HOME 517 PARK HEIGHTS AVE BALTO 21215 medicai 23. PART I. Enter the diseases, or complications the caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line. Approximata Intarval Between IMMEDIATE CAUSE (Final Onset and Death the CANCER disease or condition resulting in death) OLON 10 mos event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate ceuse. Enter UNDERLYING signed by the attending physician Health and Mental Hygiene prior CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF)that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? IVER METASTASES PERFORMED? 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN M OR ATTENDING PHYSICIAN: The law 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) EXAMINER? certificate I HOSPITAL: OTHER: 4 □ Nursing Nome 5 □ Reeldence 8 X Other (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED After this ce leath with ti marked, 1 Natural 2 Accident 5 Pending 1 YES 2 NO ВУ After I Investigation 28e. PLACE OF INJURY — At home, ferm, atrast, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 ETED. 8 Could not be DIRECTOR: / 28 1 4 Homicide determined 29e. CERTIFIER COMPL 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end piece, and due to the ceuse(s) end menner ee stated. TO THE FUNERAL ID THE FUNERAL ID BE filed within 72 h (Check only one) HOSPITAL MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(a) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE aul Lalens 2504 95 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) KENDALL 2300 DULANEY VALLEY RD. FAULKNER TOWSON, MD 21204 3. PEGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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MAR	5 should notified	2	19e. INFORMANT'S NAME (Type/Print)							Number, City or Tov	n, State, Zip C	ode)	
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RE SE	st ba		20a. METHOD Of-DISPOSITION 1 Burlet 2 Cremation 3 Rem	20b. PL	ACE AND DATE	OF DISPOS	SITION (Na	me of			CATION - CI	ly or Town	State
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ALTIMORE, death. Page 6 may be			21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	/	22.	NAME AN	D ADDRES	S OF FACILITY	neral H	ome PA		
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Α. 02:00 AM SUL 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. lest birthdey) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 212-48-8155 Balltimore, Md. 83 1 M 2 XF Feb 07,912 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Johns Hopkins Bayview Geriatric Center Baltimore City N/A RESIDENCE OF DECEDENT 10a, STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? N/A Baltimore City Maryland 1 X YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 715 Willow Ave. 21212 U.S.A. funeral director, page 5 should be detached for use as the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Markean, Puerto Rican, stc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White aic Specify: White BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married В 3 Widowed 4 Divorced BE COMPLETED 15. DECEOENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest College (1-4 or 5+) Elementary/Secondary (0-12) **Unemployeed** 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maide Clarence Milton Bay Catherine Aloysius Dobbins notified at 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Richard Beebe 10236 Hickory Ridge Rd. Columbia, Md. 21044 pe 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must OATE Triangletopy Service Corp. 8-01-95 Towson, Maryland 4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Jeffrey L. Gair Leonard J. Ruck, Inc. the 5305 Harford Road Baltimore, Maryland 21214 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart fellure. List only one cause on each line. the medical completely filled in by Approximata interval Between 6 IMMEDIATE CAUSE (Final Onset and Death cremation, disease or condition resulting in death) TO PR AS A CONSEQUENCE OF): event. MOS DIVISION OF VITAL RECORDS, P.O. BOX 68760 in and com to burial, (telemia traumatic CERTIFICATION Sequentielly list conditions, QUE TO (OR AS A CONSEQUENCE OF). if any, laeding to immediate cause. Enter UNDERLYING uires that the death certificate be e signed by the attending physician Health and Mental Hygiene prior to neumania CAUSE (Diseese or Injury other OUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in deeth) LAST 10 PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? mild PERFORMED? becubit &chizophunia any 1 YES 2 NO shows a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO I UNCERTAIN 1 TYES 2 NO been t PHYSICIAN: has by Dept. DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Hen certificate t HOSPITAL: OTHED:
Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 6 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, this (Natural Natural 5 Pending М 1 YES 2 NO ВҰ After death Investigation 2 Accident 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) Sulcide 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) 66 8 Could not be DIRECTOR:) COMPLETED 4 Homicide 28 determined 29e. CERTIFIER ERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data end place, and due to the cause(a) and manner as stated. HOSPITAL (FUNERAL (WITHIN 72 h TO THE HOSPITAL
TO THE FUNERAL
De filed within 72 h
IMPORTANT: If i MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED BE 8 2

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

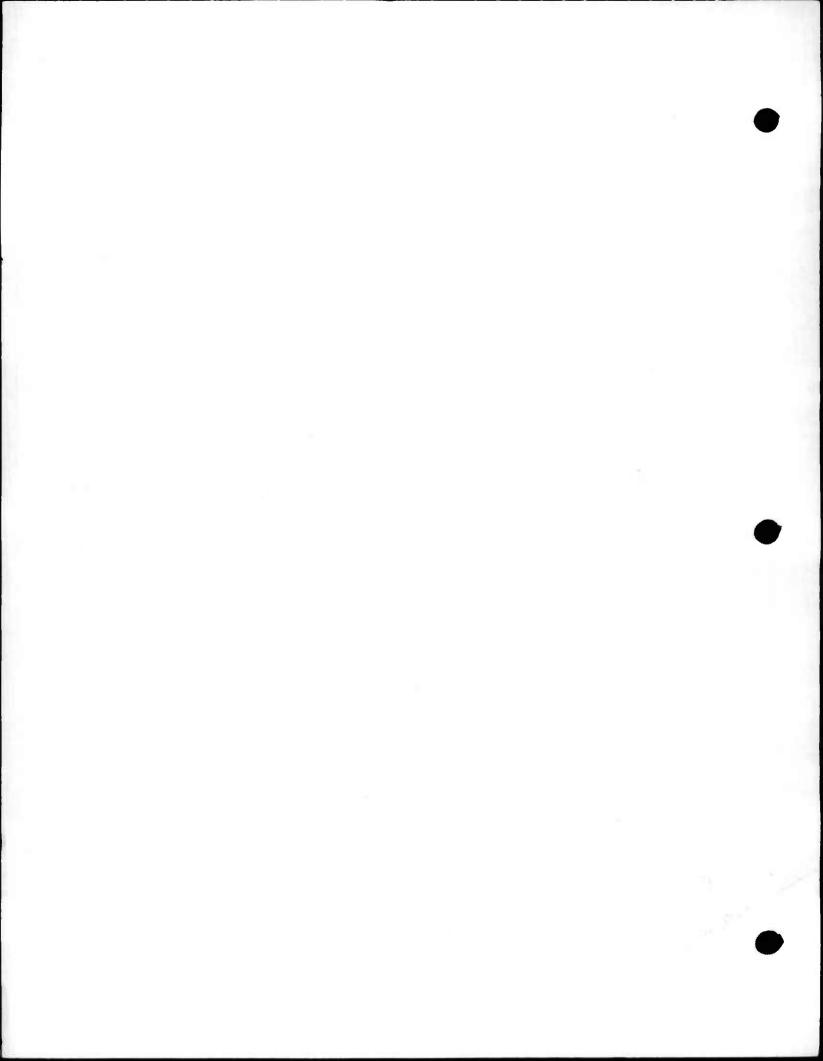
REGISTRAR'S SIGNATURE

31. OATE FILED (Month, Day, Year,

1 1995

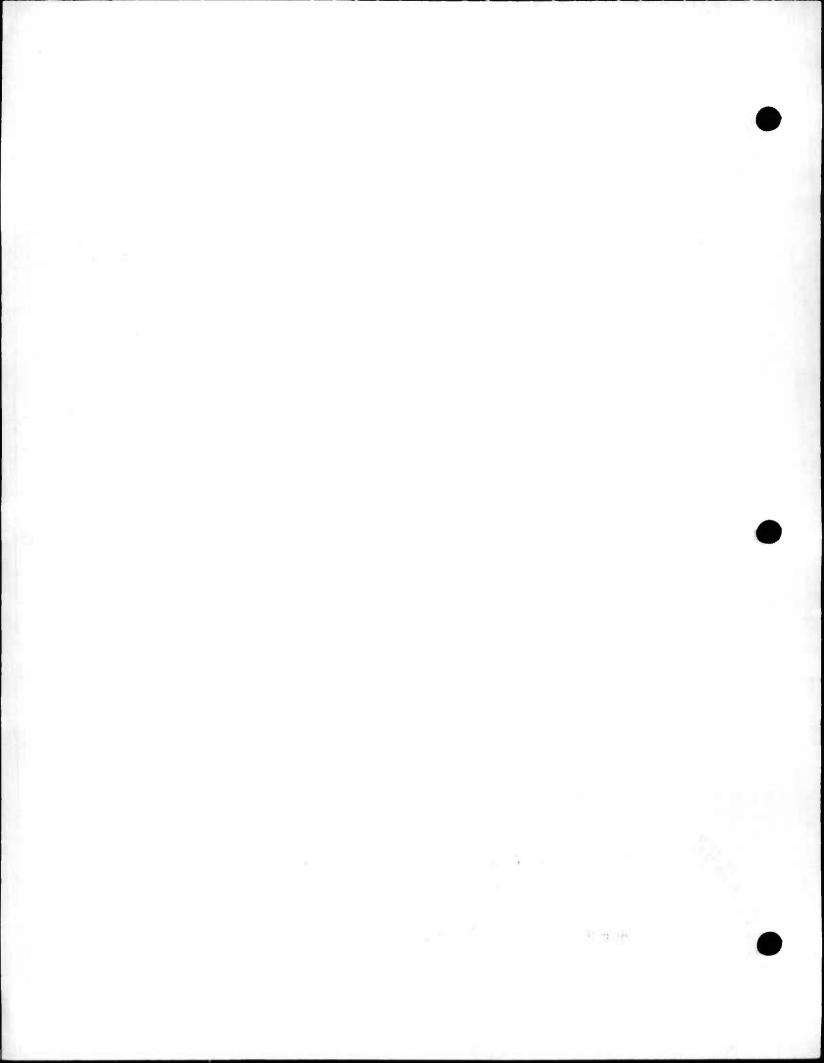
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pa	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be
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	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF	HEALTH AND		YGIENE EG. NO.		
	1. OECEOENT'S NAME (First, Middle, Last) NICH	OLAS LOUI		LICH		2. DATE OF I		YEAR	3. TIME OF DEATH 3:30 A. M
	220 20 2070		(In yrs. last birthday) 1 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF E (Month, De	NRTH	8. BIRT	THPLACE (State or Foreign
OR	9a. FACILITY NAME (If not institution, give stre 1738 GREENSPRI		ROAD		OR LOCATION DE D VENSON	DEATH	9c. C	OUNTY OF	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MARYLAND BAT	TIMORE	10c, CiT	Y, TOWN OR LOC	ATION VENSON				10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER				Of. ZIP CODE		100	CITIZEN OF	1 YES XX NO
FUNERAL	1738 GREENSPE	RING VALL	EY ROA	1	211	53		U.S	
B	11. MARITAL STATUS 1 Never Merried XX Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IF FDRCES? 1 YES IF YES, GIVE WAR DR DA	ATES	If yes, s	CENDENT OF HISPA pecify Cuben, Maxic SXX ND Spec	an, Puerto Rican	pecify Yea or No- i, etc.)	Spe	CE American Indian, ick, White, atc. icity: WHITE
윤	15. OECEDENT'S EOUCA (Specify only highest grade of	ATION ompleted)	16a. DECEDENT'S (Give kind of v	vork done during n	ION tost of working	16b. KIN	D OF BUSINESS	INDUSTRY	
COMPLET	Elementery/Secondary (0-12)	College (1-4 or 5+) PLUS	PSYCHI		ľ	S	ELF E	MPLO	YED
NO	17. FATHER'S NAME (First, Middle, Last)		·		16. MOTHER'S N	AME (First, Middle	, Maiden Surnam	•)	
BE E	NICHOLAS LOUI	S BALLIC			MARY	LUCIL		IDOV	ICH
2	19a. INFORMANT'S NAME (Type/Print) CATHARINE J.BAL		E) 1738	GREEN	and Number or Rural NSPRING	VALLE	Y RD.	Zip Code) STE	21153 VENSON, MD.
	20s. METHOD OF DISPOSITION A Burial 2 Cremation 3 Ramov 4 Donation 5 Other (Specify)	ral from State 20b	PLACE AND DATE OF STREET, Crematory or of T • THOMA	of DISPOSITION (Finer piece)		OATE	20c. LOCATION		
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	I • IIIOPIA	22. NAME	ND ADDRESS DF F	ACILITY			FOREST, MD.
3	+ R. H. Kur					ROAD,		AND ORE,	SONS MD.21212
	23. PART i. Enter the disease, or co ehock, or heart failure. Li iMMEDIATE CAUSE (Final disease or condition resulting in death)	SARC	tha death. Do nach line.		ode of dying, su	ch ae cerdiac	or reapiratory	arreat,	Approximate interval Between Onset end Death
TION	Sequentially liet conditions, if eny, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	ŋ:					
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
	PART ii. Other aignificant conditions	contributing to death b	ut not requiting i	n the undariyis	ng cause given in	Part I. 24a.	WAS AN AUTOPS	SY 24	b. WERE AUTOPSY FINDINGS
MEDICAL						10	PERFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME					1		p = C000		1 TES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRI		F DEATH YE		UNCERTAI	и 🗆 📗			
SIC		HOSPITAL:		OTHER:	me.X6X Residence	6 Other (Soi	nc/fv)		
표	27. MANNER DF OEATH XX Natural 5 Pending	26a. DATE DF INJURY (Month, Day, Year)	28b. TIME	OF 28c IN	JURY AT ORK?		E HOW INJURY	OCCURED	
₽	2 Accident Investigation	28s. PLACE DF INJURY	At home to a		YES 2 NO				
ETED	3 Suicide 8 Could not be 4 Homicide determined	building, atc. (Spec	ny)			City or Tov			Route Number,
COMPLETED	(Check only one) 2 MEDICAL EXAMINER:	AN: To the best of my knowl On the basis of	edge, death occurre	d at the time, dat n, in my opinion,	a and place, and du	to the cause(a)	and manner as	stated.	(a) and manner as stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	ital)		29c LICENSE NU	MBER 2 1 2			D (Month, Day, Year) 9-95
5	30. NAME AND ADDRESS OF PERSON MICE. ERIC J. SEIFTI	COMPLETED CAUSE OF DEA			DATE	フマン		_	
	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNA		TP KO	AD, LUT	HEKVII	JLE , MA	KYLA	ND,21093
	AUG 0 1 1995		ar Radall						



Pages 1, 2, 3 should

permit.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNESTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans	De med within / 2 hours after death with the State Dept. of Heath and Mental Hyghere prior to durial, cremation, or removal.	IMPURIANES ITEM 28 IS MARKED, OF ITEM 23 Shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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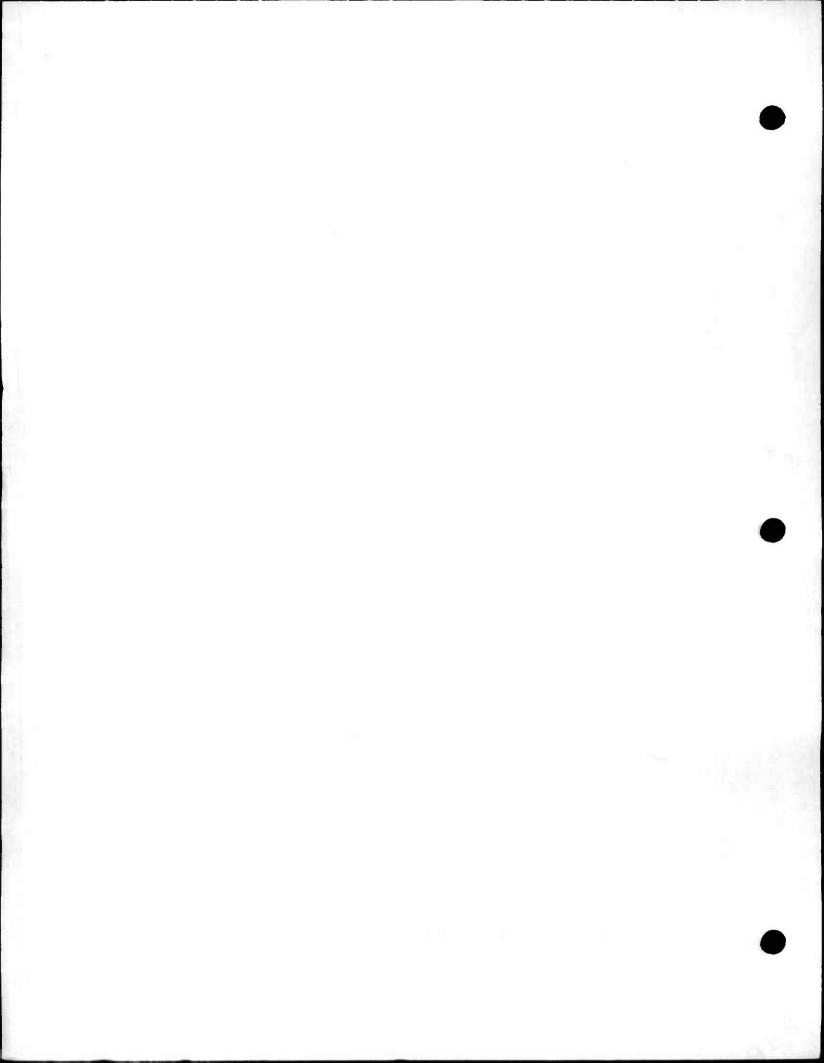
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31. DATE FILED (Month, Day, Year)

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OFATN Aubrey Lynn Beetham July 28 1995 2:00 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday 7. DATE OF BIRTH (Month, Day, Yea IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign DAYS HOURS 216-05-4661 1 - M 2 X F 84 YRS. December 11 1910 Virginia 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Manor Care-Towson Towson Baltimore RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Towson 1 - YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 305 E. Joppa Road Apt. 1610 21286 United States 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puarto Rican, etc.) 12. WAS OECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 X NO 14. RACE — American Indian, Black. White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 YES 2 NO BY 3 X Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EOUCATION (Specify only highest grade comple 16s. DECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INQUISTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Sigurd Lars Jensen, Sr. Virginia Elizabeth Jensen Crowley BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Virginia Beetham 1640 Sunnyside Ave. Lansing, Michigan 48910 20a, METHOD OF OISPOSITION
1 X Burlal 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State Moreland Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Carney, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home, Inc. 6500 York Road Baltimore, MD 21212 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert fellure. List only one cause on each line. **Approximete** interval Between **IMMEDIATE CAUSE (Final Onset and Death** disease or condition_ resulting in death) year DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury QUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES TO UNCERTAIN TO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER:
4 Hursing Home 5 Residence 6 Other (Specify) 1 YES 2 = 1 Inpetient 2 ER/Outpetient 3 DOA 27. MANNER OF OEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF 28d. DEŞCRIBE NOW INJURY OCCURED 1 Natural 1 YES 2 NO BY Investigation 2 Accident 3 Suicide 28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, COMPLETED 8 Could not be 4 Homicide determined 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 286. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 32 lam

Joseph Adams 7401 Osler Drive #206 Towson, Maryland 21204 32, REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

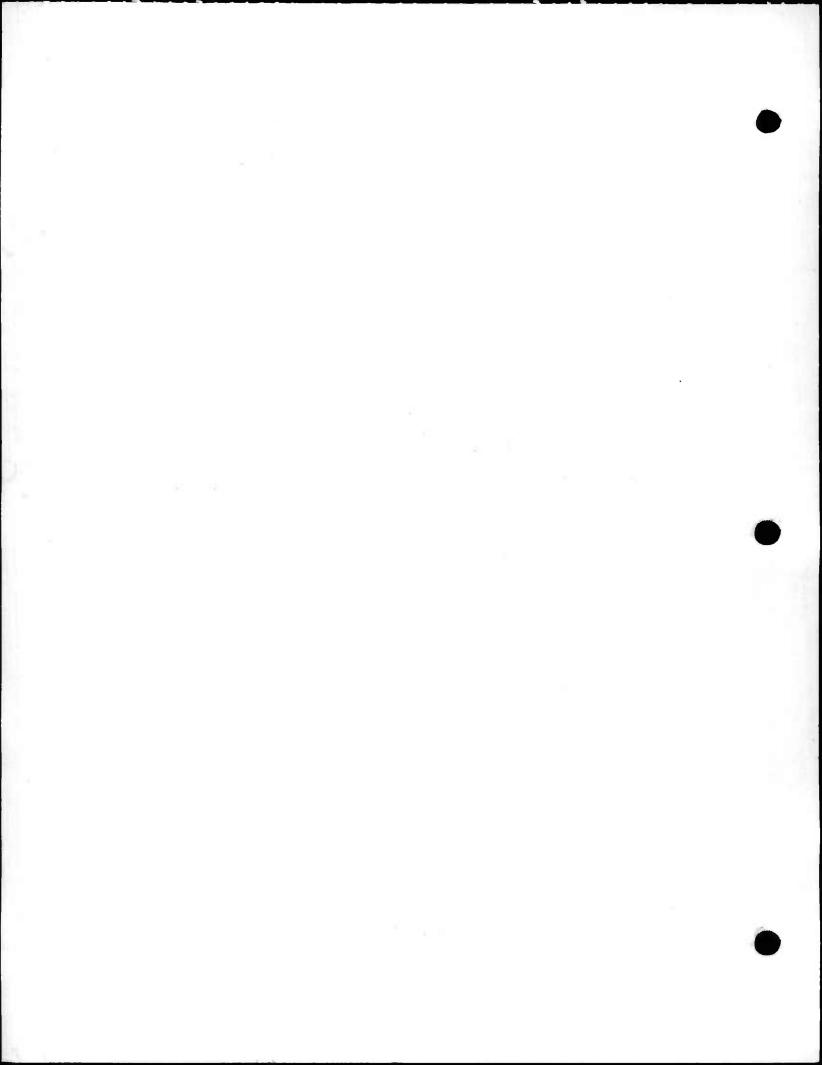
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

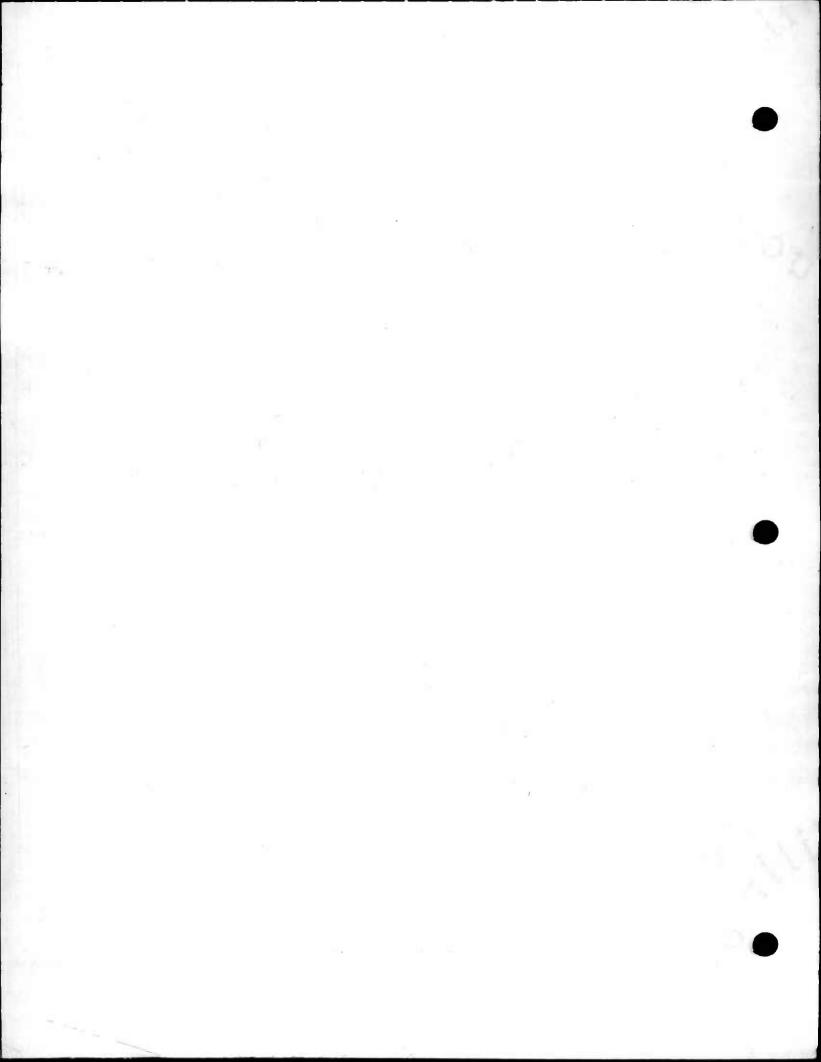
1 - STATE REGISTRAR	OIAIL OF MAIL	CERTIFIC	CATE OF	DEATH	WENTAL	REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATH			3. TIME OF DEATH
BABY BARMADIA					JULY	2		YEAR	1320 PH
4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, D	BIRTH		8. BIRTHP Country)	LACE (State or Foreign
	1 💢 M 2 🗆 F	YRS.	ONTHS DAYS	HOURS MIN.	Liely		1995	0.1	yland
9a. FACILITY NAME (If not institution, give str		9		OR LOCATION OF	EATH			NTY OF DE	
UNIVERSITY OF MI	IRYLAND		BALTI	MORE					
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		Inc CITY	TOWN OR LOC	ATION					
		ioc. cri i,	TOWN ON LOC	ATION					IOd. INSIDE CITY LIMITS?
10e. STREET AND NUMBER			1.	Of, ZIP COOE					YES 2 NO
			- 1	UI. ZIP COOE			10g. CITE	ZEN OF WH	AT COUNTRY?
11. MARITAL STATUS	12. WAS DECEDENT EVER	IN II S ADMED	12 WAS DE	CENOENT OF HISPA	NIC 08101410 #				
1 Never Married 2 Married	FORCES? 1 YE	S 2 NO	Il yea, s	pecify Cuban, Maxic	en, Puerto Rice	in, etc.)	or No-	Black,	– American Indien, Whita, aic.
3 Wildowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 - YE	S 2 NO Speci	fy:			Specify:	Black
15. DECEDENT'S EDUC		16a. DECEDENT'S US	SUAL OCCUPAT	ION	16b. KI	ND OF BUS	SINESS/IND	USTRY	
(Specify only highest grade (Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of wor life. Do NOT use i	k done durina n	nost of working			Fred I p. S.		
17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NA	ME (First, Midd	fle. Maiden	Surname)	-	
Wilhelmia Johnson				Gloria			,		
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street	and Number or Rural			State Zin	Corfel	
				Road-Balt					234
20a. METHOO OF DISPOSITION		0b. PLACE AND DATE OF			OATE	_		City or Town	
1 Donation 5 Other (Specify) LN_	val Irom State 人だれたの カロ moil	emetery, crematory or othe	r place)	varrie or	OATE	200, 000	CATION —	City or low	, Stata
21. SIGNATURE OF FUNERAL SERVICE LICE				NO ADDRESS OF EA	ACII ITY	1			
1 8 1111	1111 000	vaue, voc.	State						nore Street
January /	e Coure	-	Rm.0	26-Baltin	nore, 1	laryl	and 2	21201	-1559
23. PART i. Enter the diseases, or co	emplications that caus	ad the desth. Do not	antar the m	oda of dying, suc	h ss cardisc	Dr respi	ratory arr	est,	Approximsta
shock, or heart fallure. L	ist only one cause on	aach lina.							Interval Batween Onset and Death
disease or condition	PULMONAR	Y HEMORR	HHGE						Mil i
resulting in death)		A CONSEQUENCE OF):							sk hours
	RESPURATO		: 6 5	VIASOME					17 1,000
Sequentially rist conditions,	DUE TO (OR AS	A CONSEQUENCE OF):	- 7 /	CONTOUR					1 ~ News
if any, leading to immadiata cause. Enter UNDERLYING	PREMATU	RITY							12 hours
CAUSE (Disease or Injury that initiated events		A CONSEQUENCE OF):							10000
resulting in desth) LAST	SEPSIS								12 hours
0.									
PART II. Other significant conditions	contributing to desth	but not reaulting in	tha underlyi	ng cause givan in	Part i. 24	e. WAS AN			VERE AUTOPSY FINDINGS
					13	YES 2		0	OMPLETION DF CAUSE
						da			F DEATH?
DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEATH YES	Пиог	UNCERTAI	N \square				- 120 T JA 110
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH							
	HOSPITAL:		THER:	me 5 🗆 Residença	e - On (0				
EXAMINER?	1 Minpetient 2 ER/Ou		- Indiania Lio	THE 3 - HERICETICS	a Other (5)	oeciny)			
	1 Stopatient 2 ER/Ou 28a. DATE OF INJURY		F 28c IN	JURY AT	1	DE HOW IN	LILIBY OCC		
1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	1 Linpatient 2 ER/Ou	28b. TIME C	YW	JURY AT ORK?	28d. DESCRI	BE HOW IN	JURY OCC	UREO	
1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME C	Y M 1 🗆	ORK? YES 2 NO	28d. DEŞCRI				
1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME C	Y M 1 🗆	ORK? YES 2 NO	28d. DESCRI				te Number,
1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJUR building, etc. (Sp	28b. TIME C INJUR RY — At home, lerm, atre ecity)	Y W 1 □	ORK? YES 2 NO	28d. DESCRI 281. LOCATIO City or To	ON (Street a own, State)	nd Number	or Rurel Rou	te Number,
1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29e. CERTIFIER (Check only 1 CERTIFVING PHYSIC)	28e. PLACE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Sp	28b. TIME (INJUR 27 — At home, lerm, etre ecity)	Y M 1 et, lectory, offi	ORK? YES 2 NO Ca e end place, end due	28d. DESCRI 28l. LOCATIC City or To	ON (Street a own, State)	nd Number	or Rurel Rou	
1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be detarmined	28e. PLACE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Sp	28b. TIME (INJUR 27 — At home, lerm, etre ecity)	Y M 1 et, lectory, offi	ORK? YES 2 NO Ca e end place, end due	28d. DESCRI 28l. LOCATIC City or To	ON (Street a own, State)	nd Number	or Rurel Rou	
1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29e. CERTIFIER (Check only 1 CERTIFVING PHYSIC)	28e. PLACE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Sp	28b. TIME (INJUR 27 — At home, lerm, etre ecity)	Y M 1 et, lectory, offi	ORK? YES 2 NO Ca e end place, end due	28d. DESCRI 281. LOCATIO City or To	ON (Street a own, State)	nd Number	or Rurel Rou id.	
1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29e. CERTIFIER (Check only one) 1 CERTIFVING PHYSIC MEDICAL EXAMINER	28e. PLACE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Sp	28b. TIME (INJUR 27 — At home, lerm, etre ecity)	Y M 1 et, lectory, offi	ORK? YES 2 NO ca e end place, end due death occured at the	28d. DESCRI 281. LOCATIC City or R to the cause(in time, data and	ON (Street a own, State)	nd Number oner as state of due to the 29d. DATE	or Rurel Round, ed. e cause(a) e	nd manner ea stated.
1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29e. CERTIFIER (Check only one) 1 CERTIFVING PHYSIC MEDICAL EXAMINER	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Sp. 1AN: To the best of my kno: On the basis of exeminating the second of the second of the basis of exeminating the second of the secon	28b. TIME C INJUR 2Y — At home, lerm, stre- ecity) wledge, death occurred on on end/or investigation,	Y M 1 □ set, lectory, offile at the time, det	ORK? YES 2 NO ca e end place, end due death occured at the	28d. DESCRI 281. LOCATIC City or R to the cause(in time, data and	ON (Street a own, State)	nd Number oner as state of due to the 29d. DATE	or Rurel Rou id.	nd manner ea stated.
1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Could not be detarmined 29e. CETIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Sp IAN: To the beat of my kno : On the basis of exeminet	28b. TIME C INJUR 2Y — At home, lerm, stre- ecity) wledge, death occurred on on end/or investigation,	Y M 1 □ set, lectory, offile at the time, det	ORK? YES 2 NO ca e end place, end due death occured at the	28d. DESCRI 281. LOCATIC City or R to the cause(in time, data and	ON (Street a own, State)	nd Number oner as state of due to the 29d. DATE	or Rurel Round, ed. e cause(a) e	nd manner ea stated.
1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATORE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Sp IAN: To the beat of my kno : On the basis of exeminet	28b. TIME C INJUR 27 — At home, lerm, etre ocity) wiedge, death occurred a lon end/or investigation, leading to the control of the control	Y M 1 □ set, lectory, offile at the time, det	ORK? YES 2 NO ca e end place, end due death occured at the	28d. DESCRI 281. LOCATIC City or R to the cause(in time, data and	ON (Street a own, State)	nd Number oner as state of due to the 29d. DATE	or Rurel Round, ed. e cause(a) e	nd manner ea stated.



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Pages 1, 2, 3 permit. funeral director, page 5 should be detached for use as the burial-transit the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 retained by the f filled in by 0 and completely fi to burial, cremation DIVISION OF VITAL RECORDS, P.O. BOX 68760 signed by the atten Health and Mental Dept. has this certificate h with the State [HOSPITAL OR ATTENDING PHYSICIAN: After t death DIRECTOR: A hours

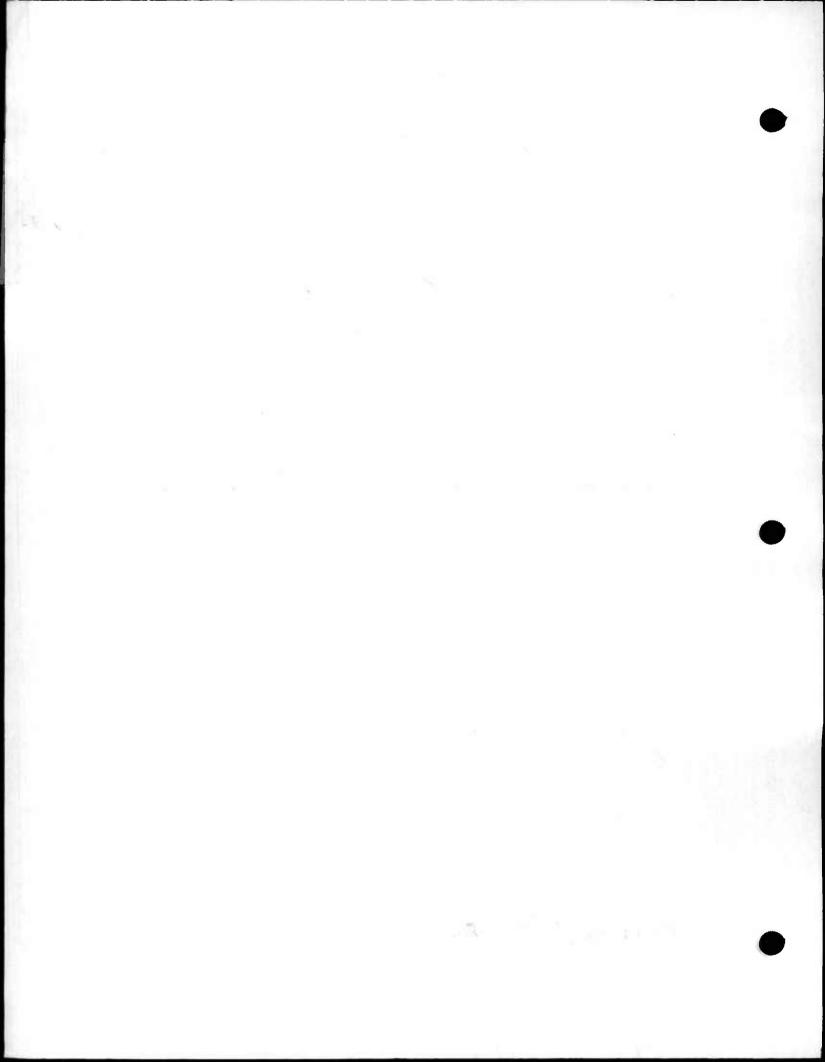
FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MARY BREMMER 1995 11. 45A M JULY 24 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 M 2 X F 9a. FACILITY NAME (If not institution, give street end number) 8-2-16 unknown 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Baltimore Harbor Hospital Center DIRECTOR Baltimore City RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY aryland Anne Arundel Glen Burnie 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 406 Morris Hill Avenue 21061 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES BY 1 TES 2 NO Specify spectly: White 3 Widowed 4 Divorced Unknown unknown COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) unknown unknown unknown unknown 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) notified at BE unknown unknown 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Sulvia Asaso 406 Morrishill Avenue-Glen Burnie, MD. pe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must 4 Donatton 5 Other (Specify) in state removal unknown unknown link unknown 21. SIGNATURE OF JUNERAL SERVICE LICENSEE Ronald Wade, Dir. examiner 22. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559 the medical 23. PART LEnter the diseases, or complicatione that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Betwe IMMEDIATE CAUSE (Finel Onset and Death diseese or condition resulting in deeth) HEART FAILURE CONGESTIVE 1 WEEK event, DUE TO (OR AS A CONSEQUENCE OF): TWO WEEK LARGE CELL LYMPHOMA DIFFUSE traumatic CERTIFICATION Sequentially liet conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events reaulting in death) LAST PART II. Other eignificant conditione contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Atrial Fibrillation Failure, ALUTE RESPIRATORY 1 TYES 2 1 NO Anemia Coronary Heart DISEASE 1 YES 2 -NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN XX PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL:
1 Empetient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Reeldence 8 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 286. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investigation M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — Al home, larm, street, lactory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide ETED. 99 8 Could not be 4 Homicide 28 COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and menner as stated. TO THE HOSPITAL OF THE FUNERAL D BE filed within 72 ho 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(e) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year, BE FIRST YEAR Bothacke RESIDENT 244/614-19 DULY 1995 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BINU THOMAS CHACKO, 2106 HARMONY WOODS OWINGS MILL 32 REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) AUG 1 1995 of the Marcheon Reveal



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THE HOSPITAL OR ATTENDING PHYSICIA	O THE FUNERAL DIRECTOR: After this certified mithing 72 hours after death with the	MPOSTANT: If Item 28 is marked, or

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	FOR STATE REGISTRAR	STATE OF MARYL		RTMENT 0				GIENE B. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEA	ATH	3. TIME OF DEATH			
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	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)			_	7. DATE OF BIRT (Month, Day, Y	тн	8. BIRTHPLACE (State or Foreign			
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OR	2 YORK RD.	1000 wind indicasory			VSON	ON OF DEA	TH .		LTIMORE			
[<u>당</u>	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	,	100 CF	TY, TOWN OR L	COATION							
DIRECTOR	MARYLAND BAL	TIMORE		OWSON	DCATION				10d. INSIDE CITY LIMITS? 1 YES 2 NO			
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N N	11. MARITAL STATUS	12. WAS DECEDENT EVER II	N U.S. ARMED	13. WAS			ORIGIN? (Spec		14. RACE — American Indian.			
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60	15. DECEDENT'S EDUC		18a. DECEDENT'S	S USUAL OCCU	PATION		T 16h. KIND (OF BUSINESS/IND				
once. COMPLETE	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+) 1YR •	(Give kind of life. Do NOT u	work done durin use retired.)	ng most of worki				Joint			
OMF.	1YR • MECHANICAL ENGINEER AIRCRAFT 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname)											
	CHESTER BOWMAN	NT.				HER'S NAME ELIZA		Aaiden Surname)	_			
BE	19a. INFORMANT'S NAME (Type/Print)	N	19b. MAILIN	ADDRESS (St				or Young State 7in	Cadal			
TO BE COM	ELIZABETH MURI		6 E <i>P</i>	NG ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) AST MAIN BLVD. TIMONIUM, MD. 21					. 21093.			
examiner must b	20s. METHOD OF DISPOSITION 1 W Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of completely, gremation, or other place) DULÂNEY VALLEY MEM. 7/95 COCKEYSVIL											
Je J	21. SIGNATURE OF FUNERAL SERVICE LICE			22. NAM	AE AND ADDRE	SS OF FACIL	LITY					
EX	Na/Ming	2 Parcel	11					& SON				
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a such as cardiac or respiratory arrest, interval.											
ant, the medical	ahock, or haart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) S. CANCEROUS (ACHEXIA) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE											
other traumatic event, TIFICATION	II Sequentially list conditions											
RTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING											
를 금	CAUSE (Disease or Injury	cDUE TO (OR AS A CONSEQUENCE OF):										
	that initiated evants reaulting in dasth) LAST		1 CONSCOULTE -	Ψ).								
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shows any injury, : MEDICAL CE	PART II. Other algnificant conditions	s contributing to death b	out not resulting	In the under	lying cause	given in Pa	art i. 24a. W	AS AN AUTOPSY ERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
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or Item	EXAMINER? t	HOSPITAL: 1 Inpatiant 2 ER/Outp	28b. TIN	4 Nursing ME OF 28c	: INJURY AT WORK?	2		(y) HOW INJURY OCC	URED			
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spital or attending physician.	ed for use as the burial-transit permit. Pages 1, 2, 3 should	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 3.4 mours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Debt, of Health and Mental Hoplene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPI	TO THE FUNER be filed within	IMPORTANT:

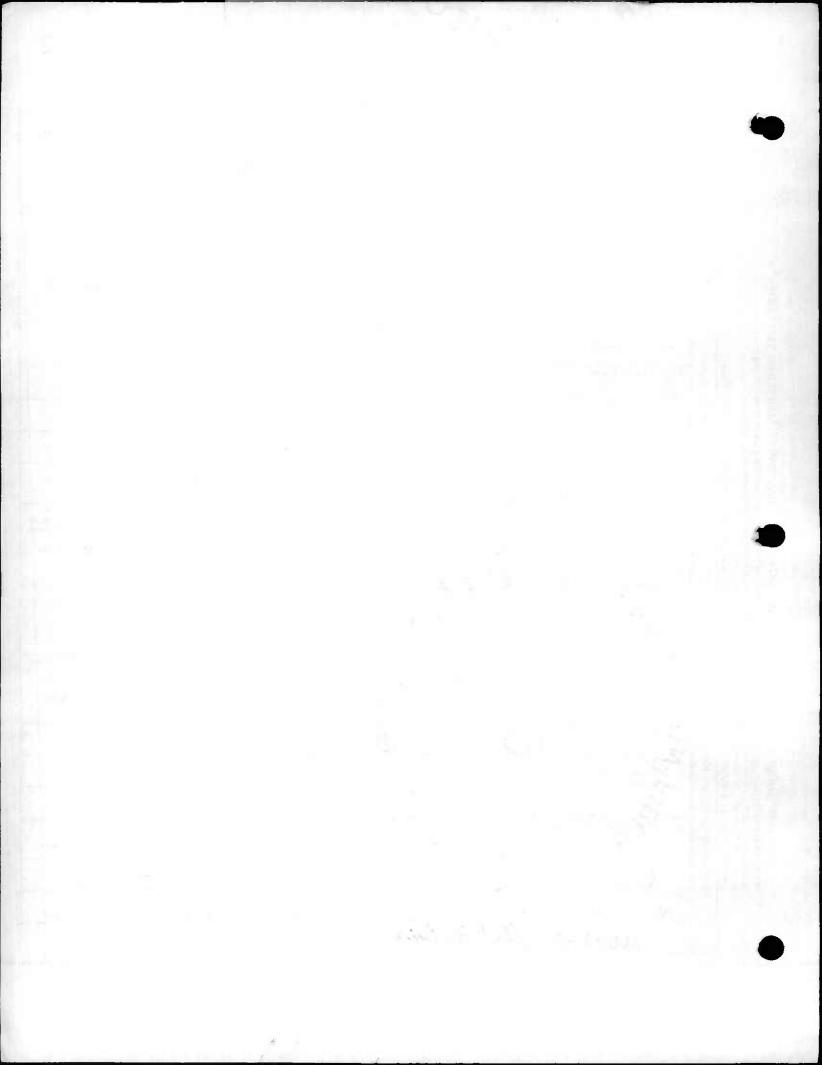
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	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Las DENA		C		ICATI	E OF	DEATH	12		EG. NO.		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I		_						1993		125 H. M
. ,	213-52-9209	1 □ M 2 🄀 F	89	YRS.	MONTHS DAVE MOURE			N.	JULY	2,19	906	MAT	PLACE (State or Foreign
~	9a. FACILITY NAME (If not institution, give	e street end number)									9c. COU	NTY OF D	EATH
DIRECTOR	6627 CHIPPEWA DE	RIVE		-	BALT	IMORE	_			E	BALTI	MORE	
IRE	MADATE 166. COUR			ry, TOWN								10d, INSIDE CITY LIMITS?	
	MARYLAND BA	ALTIMORE	MORE				MORE . ZIP CODE				40- 017	TTEN OF I	LIMITS? 1 YES 2 NO WHAT COUNTRY?
ERA	6627 CHIPPEWA DR	RIVE					212	209			10g. CI1	USA	WHAI COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES?	FORCES? 1 YES 2 NO				ENGENT OF HIS	exican, i	ORIGIN? (Sp Puerto Rican,	ecify Yes , atc.)	or No-	14. RACI Black Spec	E — American Indian, k, White, atc.
9	15. DECEDENT'S Et (Specify only highest gra		18a. C	ECEDENT'S	USUAL O	CCUPATION OF	DN ast of working		16b. KIND	OF BUS	SINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5		fe. Do NOT u	use retired.) JSEWI	_						1 HOM	1E
	17. FATHER'S NAME (First, Middle, Last) HARRY		POTEM						ME (First, Middle, Melden Surname)				RIFKIN
TO BE	19a. INFORMANT'S NAME (Type/Print)		1				and Number or R						
	DR. HOWARD BRONSTEIN #19 OLD BOXWOOD LANE LUTHERVILLE, MD 210 200. METHOD OF DISPOSITION 200. PLACE AND DATE OF DISPOSITION (Name of 200. LOCATION — City or Town, Sta												
	20a, METHOD OF DISPOSITION 1 Description 1 Donation 5 Donation	emoval from State					NS - 7-	-28-	1995	20c. LO	CATION —	City or To	wn, State
	21. SIGNATURE OF FUNERAL SERVICE	UCENSEE)		22.	NAME A	LEVINSC	F FACIL ON 8	BROS	., :	INC.		RE, MD 21215	
	23. PART Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or reepiratory arrest, shock, or heart feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE to (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death of the condition												
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):												
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PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHE	R:	ACE OF DEATH						
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TED BY	2 Accident Investigation 3 Suicide 6 Could not b determined	28e. PLACE	OF INJURY — At I	ome, ferm,	street, fact			_	Br. LOCATION City or Tow	(Street e	and Number	r or Rural F	Route Number,
COMPLETED		YSICIAN: To the best of											end manner ee stated.
BE C	2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner ee state 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Morgh, Day, Year) 7/27/94											(Month, Day, Year)	

L				28. PLACE OF DEATH (C	heck only one)
	HOSPITAL: 1 Inpatient 2 ER/Outpatient	DOA	OTHE 4 Nu	R: rsing Home 5 Residence	6 🗆 Other (Specify)
	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF URY M	26c. INJURY AT WORK? 1 YES 2 NO	28d. OEŞCRIBE HOW INJURY OCCUREO
	28e. PLACE OF INJURY — At h building, atc. (Specify)	ome, ferm,	street, fac	ctory, office	261. LOCATION (Street and Number or Rural Route Number, City or Town, State)

(Check only	1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(e) end manner ee stated.
one)	2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place and due to the course.

Howard D. Brunter MO	1.00928	7/27/95
10. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typ	e. Print)	
11 10 0		Luther W. H. Md 21093

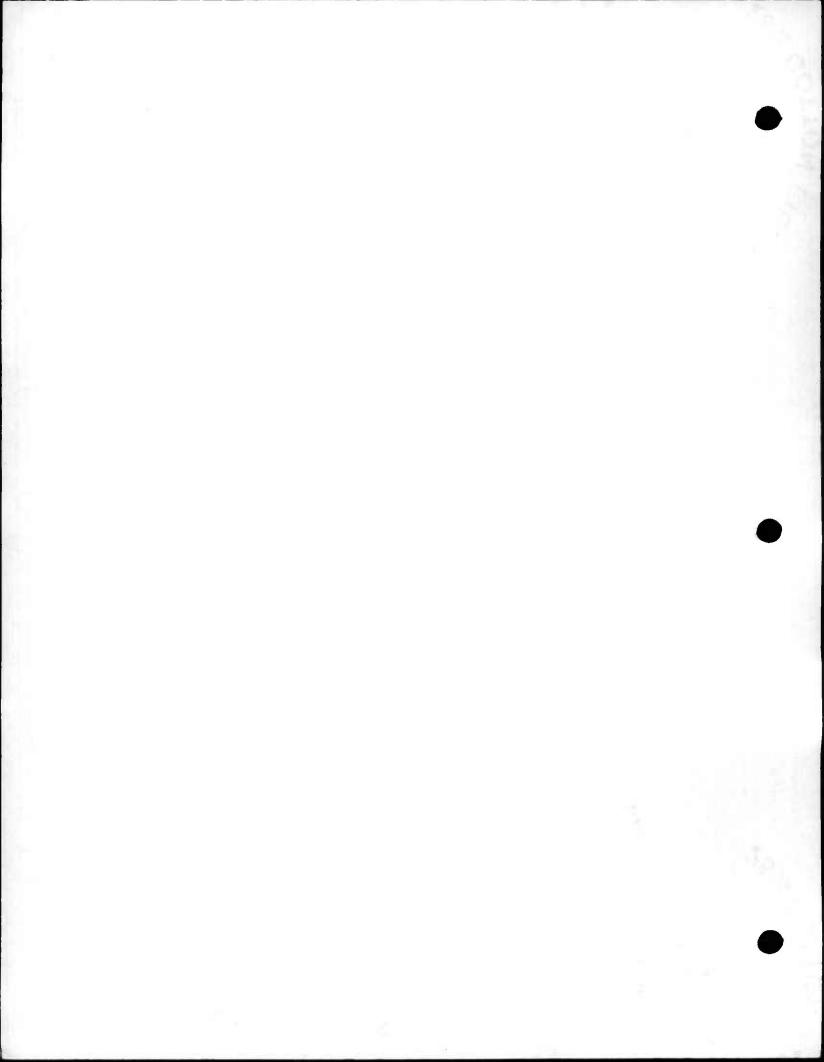
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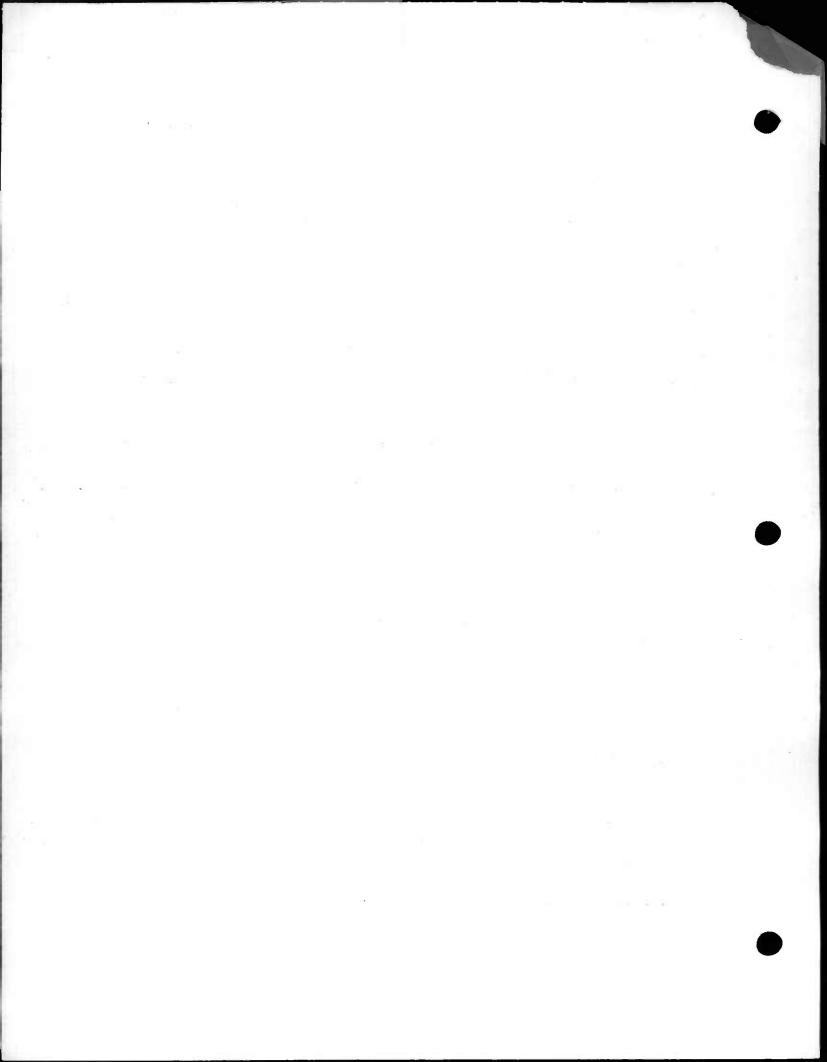
1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

			REGISTRAR			SENTIF	TOATE	JE DEALU		REG. NO			
			1. DECEDENT'S NAME (First, Middle, Las	nt)			-			OF DEATH	AY	100	3. TIME OF DEATH
			James San	nuel	Carro	11			T11	lv 29		YEAR	2:35 p m
			4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UNDER 1 YE	AR IF UNDER 24 HRS.		OF BIRTH			PLACE (State or Foreign
			212 06 3350	1 🕁 M 2 🗌 F		25 YRS.	MONTHS DA	YS HOURS MIN.	(Mon	th, Day, Year)		Country)
	phoule		9e. FACILITY NAME (If not institution, giv	Ι Λ		2.5	0.000		Jul	y 3,1	9701	Mar	yland
	3 sho	œ		e street and number)				WN OR LOCATION OF			9c. COUN	ITY OF DE	ATH
	ci .	0	9 Axis Road				Ow	ings Mil	lls		Balt	cimo	re
	5.	ပ္ပ	RESIDENCE OF DECEDENT 10e, STATE 10b, COU	UTV		400 00	TY, TOWN OR LE						
	permit. Pages	DIRECTOR	200			IOC. CIT							10d. INSIDE CITY LIMITS?
	Tj.			imore			Ow.	ings Mil	LIS				1 YES 2 NO
		ERAL	10e. STREET AND NUMBER					101. ZIP CODE			10g. CITIZ	EN OF W	HAT COUNTRY?
نے	burial-transit	Ä	9 Axis Road					2111	7			U.S	. 7
020 physician	al-tro	FUN	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S.	ARMED	13. WAS	DECENDENT OF HISP	ANIC ORIGI	N? (Specify Yes	or No-	14. RACE	- American Indian.
215-0020 attending physic	pr		1 K Never Married 2 Married	IF YES, GIVE W	YES 2	E NO	It yes	i, specify Cuban, Maxi YES 2 → NO Spec	can, Puarto	Rican, atc.)	2011		White, atc.
215-0	the the	ВУ	3 Widowed 4 Divorced		200		'	ony.			эрвин	White	
215 aften	e as	8	15. DECEDENT'S EI	DUCATION	16a,	DECEDENT'S	USUAL OCCU	PATION	16	b. KIND OF BUS	SINESS/INDL	JSTRY	
21.0	for use	E.	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4 or 5		(Give kind of life. Do NOT u	work done during se retired.)	most of working					
o je		7	5	College (14 of 5 t	"	No	one				n/a		
AND the hospital	detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)			-		40 1400045040					
₹ ₹	at o	_	Donald Carroll S	2r	16. MOTHER'S NAME (First, Middle, Malden Surname) Rosemarie Martin								
8 3	Pa Pa	BE	19a, INFORMANT'S NAME (Type/Print)	D4. •							rtin		
MARYLAND 21 retained by the hospital or	5 should notified	၉		_				set and Number or Rurs					
- 8	be age		Donald Carroll, S	Sr.		9 Sl:	ip Stre	eam Court	Midd	le Riv	er, M	aryl	and 21220
E E	st ba		20a. METHOD OF DISPOSITION 1) Burial 2 Cremation 3 Re	mount from State	20b. PLAC	EAND DATE	OF DISPOSITION	N/Name of	DAT	F 20c LO	CATION - C	lify or Tow	n State
0 0	funeral director, p		4 Donation 5 Other (Specify)	movar from State	_ Holl	y HII	I Mem.	Gardens 8	8/2/9	5 Balt	imore	Co.	,Maryland
ALTIM death. Page	e funeral dir I. examiner		21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			22. NAM	E AND ADDRESS OF I	FACILITY				77
ath.	nue:		11 /)	0	1		Bruz	dzinski E	uner	al Home	e P.A		
B P	e = e		the B	073-	1		1407	Eastern	Ave	Baltim	ore. I	Marv	land 21221
S after	d in by th or remove medical		23. PART i) Enter the diseases, D	r complications the	t caused the	death. Do	not enter the	mode of dying, au	ch aa car	diac or reapl	ratory arre	ent,	Approximate
hour	De or		shock, or heert failure	B. List Dnly Dne Ceu	ise Dn each li	ne.							Interval Between
62	the the		disease or condition	CAR	DIOM	Unp.	ATH	1					Onset and Death
9 E	ompletel Il, crema event,	ŀ	resulting in death)		(OR AS A CONS	*		/					several mor
9 / pag	al. c						•						
executed	buri buri	N	Sequentially list conditions, Due to (or as a consequence of): Due to (or as a consequence of):										Congenita Syrsago
X a	or to	RTIFICATION	if eny, leading to immediate	DUE TO	(OR AS A CONS	S A CONSEQUENCE OF):							
	prin tr	2	CAUSE (Disease or injury	c 3/12	HORT	10 V	ALVE	4 CE	MEN	77		Syrsago	
Certificate	othe othe	1	that initiated events	DUE TO (OR AS A CONSEQUENCE OF): SIP AORTIC VAWE REPLACEMENT DUE TO (OR AS A CONSEQUENCE OF):									
J. €	endi Hy	#	resulting in death) LAST Mental Retardation									congenite	
S, P	y the att d Menta injury.	CE	DADT II Other significant conduct		Term Internation								
KDS, at the dea	T Pd T	EDICAL	PART II. Other aignificent condition	ona contributing to	deeth but not	t resulting	in the underl	ying ceuse given i	n Part I.	24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
0 =	any	8								1 TYES 2	THO		COMPLETION OF CAUSE OF DEATH?
41 3	Heal Heal	ME											1 TYES 2 NO
L MEC	ft. of		DID TOBACCO USE CON	TRIBUTE TO CA	USE OF DE	ATH Y	SINO	LINCEPTA	IN \Box				
AL he law	has been Dept. of n 23 sho	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	1			TH (Check only o						
AN: Th	State (2	EXAMINER?	HOSPITAL:			OTHER:						
CIA C	the the	ž I	27. MANNER OF DEATH	1 Inpetient 2				lome 5 (5 Residence	7				
2 \$	his c	ᆲ	1 Natural 5 Pending	28a. DATE OF (Month, De		28b, TIM	IE OF 28c.	INJURY AT WORK?	28d. DE	SCRIBE HOW II	JURY OCCU	JRED	
و ع	After this death with	BY	2 Accident Investigation				M 1	YES 2 NO					
DR ATTENDING PHYSICIAN: The	< 0 ™		3 Sulcide 8 Could not b	28e. PLACE Of building.	F INJURY — At I	home, term,	street, factory, o	office	28t. LOC	ATION (Street a	nd Number o	or Rural Ro	ute Number,
2 1	DIRECTOR: hours after item 28 Is	1	4 Homicide determined		(Oily	or lown, State)			
5 8	DIRE	COMPLET	29a. CERTIFIER	SICIAN: To the heat of	and the most of the		. ASS						
_ ₹	12 ×	Σ	(Check only one)	MED: On the best of	my knowledge,	demin occum	ed at the time,	late and place, and du	a to the ca	use(a) and men	ner as stated	d.	
OSP	FUNERAL within 72 TANT: If	8	2 MEDICAL EXAMI		CHITTITITICS HINDS	w investigatio	n, in my opinio	n, death occured at th	e time, date	and place, and	due to the	cause(e)	and manner as stated.
포	ed v	BE	29b. SIGNATURE AND TITLE OF CERTIFI					29c. LICENSE NO	JMBER		29d. DATE	SIGNED (Month, Day, Year)
10	TO THE FUNERA De filed within 7 IMPORTANT: 1		Saba Sid	digi	PY	rysi	con	D4	149	6	D 7	7/31	195
		2	Saba Sid	HO COMPLETED CAUS	SE OF DEATH (IT	ЕМ 27) (Туре,	Print)		<i>I</i>			/	
	1		POBOX 13					mo	21-	784			
			31. DATE FILED (Month, Day, Year)		R'S SIGNATURE								
			AUG 0 1 1995	V									
		- 11	Allis II I IUUL	June and	WHEN THE !	NAME OF THE PARTY							

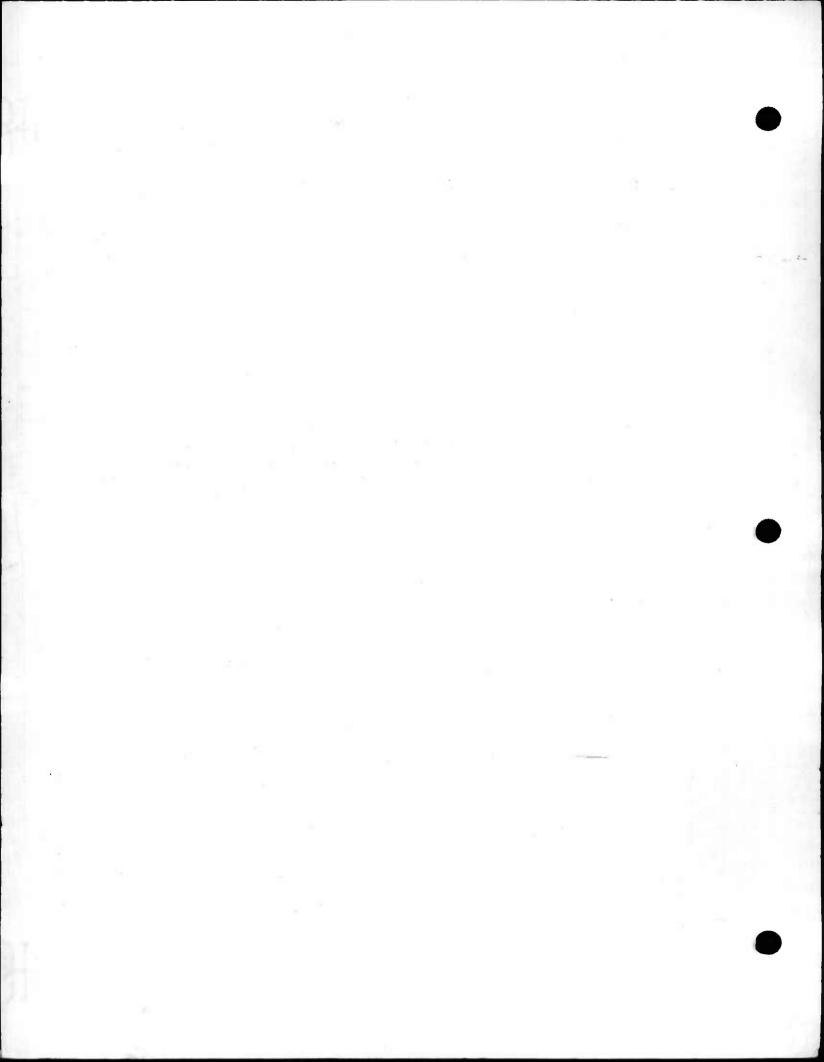


		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	HEALTH AND M	IENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Lest) HOWARD L.	CRISE, J	R.			2. DATE OF DEATH MONTH July 27,		3. TIME OF DEATH 11:00 A. M	
멸		4. SOCIAL SECURITY NUMBER 218-09-9201	5. SEX 6. AGE (I	In yrs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) 6-30-1912	8. B	IRTNPLACE (State or Foreign ountry) Maryland	
, 2, 3 should	TOR	9a. FACILITY NAME (If not institution, give : Manor Care Ruxt RESIDENCE OF DECEDENT			96. CITY, TOWN	OR LOCATION OF DEA		%c. COUNTY OF DEATN Baltimore		
permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNT	imore	10c. CIT	y, town on Loca Cockey	TION vsville			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
ısı	NERAL		Court		10	1. ZIP CODE 21030			DE WHAT COUNTRY?	
215-0020 attending physician. ise as the bunal-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	CENDENT OF NISPANIC Secilty Cuban, Maxican, 3 2 NO Specify:	C ORIGIN? (Specify Year Puarto Rican, etc.)		AACE — American Indian, Black, White, atc. Specify: White	
D 21215 pital or atten ed for use as	PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 1.2	College (1-4 or 5+)	16a. DECEDENT'S (Give kind of withe. Do NOT us Administ	USUAL OCCUPATION of done during more retired.)	ost of working	166. KIND OF BUI			
YLAND 21 by the hospital or be detached for u	BE COMPL	17. FATNER'S NAME (First, Middle, Last)	Crise, Sr.	Adminis	rative	16. MOTHER'S NAM	E (First, Middle, Maiden			
MARYL retained by the 5 should be notified at		19a. INFORMANT'S NAME (Type/Print)	01100, 51.	19b. MAILING	ADDRESS (Street a	Anna and Number or Rural Ro		wart n. Stata. Zio Code	*)	
	2	Mary F. Crise			Same As				,	
MORE ge 6 may lirector, pa		20a. METNOD OF DISPOSITION X Burlal 2 Cremation 3 Ram 4 Donation 6 Other (Specify)	novel from State	PLACE AND DATE OF	of disposition (Ne ther place) ALIEY Met	m. Gards.	7-31-95	CATION — City of Timoni	um, Maryland	
BALTIMORE, after death. Page 6 may be noval. cal examiner must be		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	421.	22. NAME A	ND ADDRESS OF FACI	LITY		1050 York Roa Towson,Md.	
within 24 hours spletely filled in to cremation, or releast, the medians.		23. PART i. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that caused List only one cause on as A COUNTE DUE TO (OR AS A	ich line.	roke		as cardiac or raapi	ratory arreat,	Approximata interval Batween Onset and Death	
h.O. BOX 68 th certificate be execute ending physician and co I Hygiene prior to bunia or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in daeth) LAST	с	CONSEQUENCE OF						
that the ed by the th and M any Inju	MEDICAL O	PART II. Other algnificant condition	na contributing to death bu	it not reaulting i	n the underlying	g ceuse givan in Pr	art I. 24a. WAS AN PERFOR 1 □ YES 2	MED?	24b. WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
law red as beer bept. of	PHYSICIAN: M	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		DEATH YE	H (Check only bne)	UNCERTAIN			1 YES 2 NO	
ICIAN: entifica the Sta	1XSI	1 VES 2 NO 27. MANNER OF DEATH	1 - Impatient 2 - ER/Outpa		-	e 5 🗆 Residence 6				
ON CATER THIS OF CATER THIS OF CATER WITH S marked,	ВУ РР	1 Selection 5 Pending Investigation	26a. DATE OF INJURY (Month, Day, Year)		M 1 1	PRK? YES 2 NO	28d. DESCRIBE NOW II	NJURY OCCURED		
OFVESTON OF VITA OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate h hours after death with the State of Item 28 is marked, or Item	ETED	3 Suicide 6 Could not be 4 Nomicide detarmined	28a. PLACE OF INJURY building, atc. (Specif	······································			281. LOCATION (Street a City or Town, State)		ral Route Number,	
A HOE	COMPLETE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSI 2 MEDICAL EXAMINE	CIAN: To the best of my knowle	edga, danth occurre and/or inventigation	d at the time, data n, in my opinion, d	and place, and dua to	the cause(a) and man	ner as stated. d due to the caus	se(a) and manner as stated.	
TO THE HOSPIT TO THE FUNER De filed within 7	TO BE	296. SIGNATURE AND JITLE OF CENTURE	Jan in			D-12			NED (Month, Day, Year) -27-95	
,	.	30. NAME AND ADDRESS OF PERSON WN A.H. Ghiladi, M.I			Print) VSON, Ma:	rvland				
$\langle \gamma \rangle$		31. DATE FILED (Month, Day, Year)	2. REGISTRAR' SIGNA							

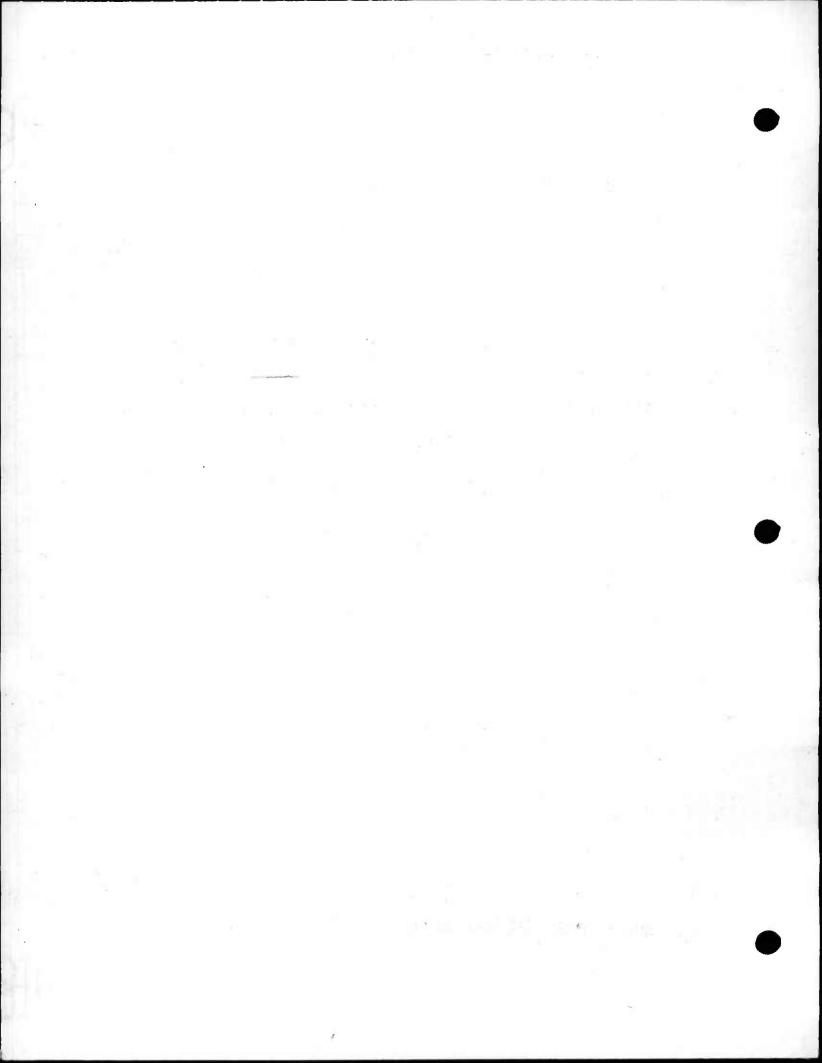


ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-726 8/10/95 t.t

		1 - STATE REGISTRAR		STATE OF I	MARYLAN	ND / DEPAR Certif					ENTAL	L HYGIENI REG. NO.	E		
		1. OECEDENT'S NAME (First, M									2. DATE	OF OEATH	AV 1	YEAR 3.	TIME OF DEATH
		MICHAEL 4. SOCIAL SECURITY NUMBER		ERNEST	T			OLE			щ	y 2	8	95 4	:55 P.M
		216-48-2509	`	5. SEX	6. AGE (In)	yrs. last birthday) YRS.	MONTHS	DAYS	HOURS	MIN.	7. DATE (OF BIRTH	948 M	SIRTHPLATE I ATVI	and
should		9e. FACILITY NAME (If not instit	tution, give st				9b. CITY	CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY			
, s	OR	REAR OF 480 S.BENTALOU STREET BALTIMORE CITY N/A													
Pages 1.	DIRECTOR		IOb. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION					10	Id. INSIDE CITY
if. Pa		Maryland	N/A				Baltimore								LIMITS?
it permit.	FUNERAL	HOMELESS					10f. ZIP CODE								T COUNTRY?
020 physician. burial-transit	UNE	11. MARITAL STATUS		12. WAS DECEDEN	NT EVER IN U	J.S. ARMED	13.	WAS DEC		/A	ORIGIN	? (Specify Yea	Or No - 14		American Indien,
0 phys	BY FI	1 Never Married 2 Ma 3 Widowed 4 Divorce		FORCES? 1 IF YES, GIVE W	YES	2 (NO		It yes, specify Cuben, Mexican, Puarto Rice 1 YES 2 NO Specify:					Black, W	/hite, atc.	
215-0020 attending physician se as the burial-tra	ED B		ENT'S EDUC	CATION		6a. DECEDENT'S	TIEUAL O	OCH IDATIO			1 404	THE OF BUILD			White
212	ETE	(Specify only hi	nighest grade ((Give kind of life. Do NOT u	work done			ng		KIND OF BUS	INESS/INDUa	тнү	
AND the hospital detached to once.	COMPLET	10				lever Wo	orkec	1				N/A			
YLAND by the hospit be detached at once.		77. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Melden Surmame) Catherine Alberta Fleming										omina			
MARY retained by 5 should b	BE (JOHN MELVIN COLE Catherine Alberta Fleming De. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
, MA be reta je 5 st	2	Catherine Alb		Cook								ena, M			
BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physic by the funeral director, page 5 should be detached for use as the burial moval.		20a. METHOD OF DISPOSITION 1 ☐ Burlat 2 ☑ Cremetion	3 🗆 Remo	oval from State	20b. Pt	LACE AND DATE	OF DISPOS	SITION (Na	ma of		DATE	20c. LOC	CATION — CIF	y or Town,	
IMO Page 6 I directo		4 Donation 5 Other (Sc 21. SIGNATURE OF FUNERAL S		FNSEE _		ro"Crem	ator	y, 1	nc.	0//3L	/95	Ball	timore	, MD	
ALTIM death, Page e funeral dire		> Opums	7 m	Dawn	F Mc	Donald	Cr	emat	ion	Socie	ty (of Mar Baltimo	yland	, Inc	2.
# ≥ E 3		23. PART I. Enter the dise	ases, pr c	pmplications the	Caused II	he death, Dn (ent enter) FIE	er de de	LCK KC	l. E	Saltimo	ore, M	D 21	
hours or re		ahock, or haar IMMEDIATE CAUSE (Final	rt fallure. L	Liat Dnly one cau	ise on aach	h line.		title tere.	Ja Di uj.	ilg, suoii .	Ib care.	Ide Di Peup	fatury arres	kg .	Approximata Interval Between Onset and Death
t agi		disease or condition resulting in death)	,	NARCOT	IC AND	ALCOHOL	INTOX	ICATI	ON_						
Da 5 0				DUE TO	(OR AS A CO	ONSEQUENCE O	F):								
at End and Secure	CERTIFICATION	Sequentially list condition If any, leading to Immedia		DUE TO	(OR AS A CO	ONSEQUENCE O	F):								
BO) ate be hysiciar prior	CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury	G												
P.O. BOX ith certificate be a tending physician al Hygiene prior to or other traum	TIF	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST													
OS, P. ne death c the attend Mental Hy njury, or		PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													
in the state of th	MEDICAL	PART II. Other aignificant	conditions	e contributing to	daath but	not reaulting	in the ur	darlying	cause g	jiven in Pa	irt I.	24a. WAS AN		AW	RE AUTOPSY FINDINGS AILABLE PRIOR TO
CO lires th signed lealth	EDÍ										-	1 YES 2	□ NO	OF	MPLETION OF CAUSE DEATH?
L RECOI law requires that as been signed bept. of Health a 23 shows any		DID TOBACCO USE	CONTR	IBUTE TO CA	USE OF	DEATH YE	S 🗆 I	NO 🗆	UNC	ERTAIN				10	YES 2 NO
1 2 6 8 a C	SICIAN:	25. WAS CASE REFERRED TO M EXAMINER?	MEOICAL	HOSPITAL:		PLACE OF DEAT	TH (Check	only one)							
OF VITA PHYSICIAN: The this certificate his with the State Dividity or item	IYSI	1 YES 2 □ NO 27. MANNER OF DEATH		1 Inpatient 2				sing Home				(Specify) A			
ING PHYSI free this c eath with marked,	r PHY	1 Natural 5 Aer		28e. DATE OF (Month, D. FOUND 7	Day, Year)	286. TIM F 0 U M	URY	28c. INJU WOI	JRY AT RK? 'ES 2 🔀		UNK N	CRIBE HOW IN	IJURY OCCUR	(ED	
0 0 0 0	D BY	2 C States	restigation ruld not be	28e. PLACE O		At home, term,							nd Number or	Augul Roun	LOUSTREET
DIVISI DR ATTEN DIRECTOR: hours after item 28 I			termined	bullotty,	анс. (ореслу)	HOME						MORE, M		BENIA	LOU SIKEET
월 국업 등	AP.			CIAN: To the best of											
TO THE HOSPITAL TO THE FUNERAL be filed within 72 I	COMPL	XIX MEDICA			xamination er	nd/or Investigation	n, in my o	pinion, de	eth occur	ed at the tim	te, date o	end place, and	d due to the c	euse(e) en	d menner es stated.
THE F	BE	29b. AGMATURE AND TITLE OF	POERTIFIER	U/2.18	,				29c. LICE	ENSE NUMBE	in.		29d. DATE S		onth, Day, Year)
2 6 5 ₹	2	30. NAME AND ADDRESS OF PI	ERSON WHO	COMPLETED CAUS	SE OF DEATH	H (ITEM 27) (Type	Print)		0	.C.M.	<u>.E.</u>		JUI	LY 2	9,1995
		MAPYARITE	1 P.	KORSU	- MO 1	III Pe	nn S	Stre	et.	Bali	tim	ore.	Marv	land	21201
		31. DATE FILED (Month, Day, Yea	n)	32. REGISTRA	AR'S SIGNATU		48								



		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF	HEALTH AND F DEATH	MENTA	L HYGIEN				
		1. DECEDENT'S NAME (First, Middle, Last	Coher	(In yrs. lest birthday)			MONT	alu 2	99	YEAR	TIME OF DEATH	
2		045-05-0602	t 🕅 M 2 🗆 F 84	YRS. HIST DIVINGAY)	MONTHS DAYS		(Mon	of Birth th, Day, Year) Y 6, 1		Country)	CE (State or Foreign	
3 should	E I	9a. FACILITY NAME (If not institution, give NORTHWEST HOSP)				HOR LOCATION OF DALLSTOWN				Y OF DEATH		
s 1, 2,	ЕСТО	RESIDENCE OF DECEDENT 10a, STATE 10b, COUN		40.00		BALTIMORE						
permit. Pages	DIRI	The second secon	TIMORE		OC. CITY, TOWN OR LOCATION REISTERSTOWN					10d. INSIDE C LIMITS? 1 YES 2		
	FUNERAL	100. STREET AND NUMBER 16 KNIGHTS COUP	RT			10f. ZIP CODE 21133	3		tog. CITIZEN OF WHAT COUNTRY?			
21215-0020 If or attending physician. For use as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? t YES	2 NO	If yes,	ECENDENT OF HISPA specify Cuben, Maxic ES 24 NO Spec	NIC ORIGI	N? (Specify Ye Rican, etc.)		American Indian, hita, etc.		
r attend	ETED	15. DECEDENT'S EO (Specify only highest grad		16a. DECEDENT'S	USUAL OCCUPA		168	b. KIND OF BU	SINESS/INDUS	STRY		
	PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT use	e retired.) AL SPR			MENS C	T.OTHTN	IG.		
A a a a	COMPL	t7. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S N	AME (First,					
RYL and by build be	BE	MAX COHEN 19a. INFORMANT'S NAME (Type/Print)		405 1414 1110		- DESCI	1110	BECCA C				
	2	BARRY H. COHEN				et and Number or Rural CT, REIST						
BALTIMORE, ter death. Page 6 may be the funeral director, page yeal.		20a. METHOD OF DISPOSITION 1 & Burlel 2 Cremetion 3 Ref	moval from State com	PLACE AND DATE O	her place)		DAT		CATION — CI		State	
		4 Donation 5 Other Specify) 21. SIGNATURE OF PUMERAL SERVICE L	СЕМВЕ	DDAS BNA	22. NAME	B LODGE 7	ACILITY		SEDALE	MD		
SAL er death he fune al.		XIIIIOhall	1. mun			LEVINSON REISTERS				MRE.	MD 21215	
theres hours aftered hours after filled in by emation, or remoti		23. PART (. Enter the diseases of shock, Dr heart feliure IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Hinte !	ech line.	eda	node of dying, su	ch as can	diec or reep	iretory arree	t,	Approximate interval Between Onset and Death	
BOX 687(ficate be executed physician and corr pe prior to burial, per traumatic ex	CERTIFICATION	Sequentielly liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	bDUE TO (OR AS A	CONSEQUENCE OF):						DAYS	
P.O. Entitical through the Hygiene property or other	ERTII	thet initiated eventa resulting in death) LAST	d	CONSEQUENCE OF						,		
CORDS, Free that the death igned by the after ealth and Mental is any Injury, or	MEDICAL C	PART II. Other aignificent condition	ns contributing to deeth be	ut not reaulting in	n the underly	ing ceuse given in	Part I.	24a. WAS AN PERFOR	MED	CDN	RE AUTOPSY FINDINGS ILABLE PRIOR TO WPLETION OF CAUSE DEATH?	
L RECO law requires th as been signed lept. of Health 23 shows an		DID TOBACCO USE CONT	RIBUTE JO CAUSE O	F DEATH YE	s 🗆 NO	☐ UNCERTAI	<u>-</u> -			1 [YES 2 NO	
A a a a E	SICIAN:	25. WAS CASE REFERDED TO MEDICAL EXAMINER?		26. PLACE OF DEAT								
OF VIT PHYSICIAN: Th this certificate with the State rked, or iten	PHYS	1 YES 2 NO	1. Inpetient 2 - ER/Outp	etlant 3 OOA	4 - Nursing Ho	ome 5 - Realdenca	Y	SCRIBE HOW I	N IIIDY OCCU	BED.		
	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	JRY V	WORK?	30d. DE.	JOHN DE HOW I	NJOHT OCCO	ED		
TSIC TTENDI TTOR: A after da	ETED I	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Speci	— A1 home, ferm, st	treel, factory, of	fice	26f. LOC City	ATION (Street or Town, State)	and Number or	Rural Route	Number,	
DIV HOSPITAL OR A FUNERAL DIREC WITHIN 72 HOURS	COMPLE		SICIAN: To the best of my knowle								d menner as stated.	
물 물을 중	BE C	286. SIGNATURE AND TITLE OR CERTIFIE	100			29c. LICENSE NU	MBER	7)	29d. DATE S	IGNED (Mor	nth, Day, Year)	
E E S S	۵ ا	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type,	Print)	1 24 3	1/7	-0-	770	142	7 1995	
3		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	YUICITT	witz	T HOS	5	3050	150	11	TACE	
		AUG 0 1 1995	Jalia Deuthar	ardall								

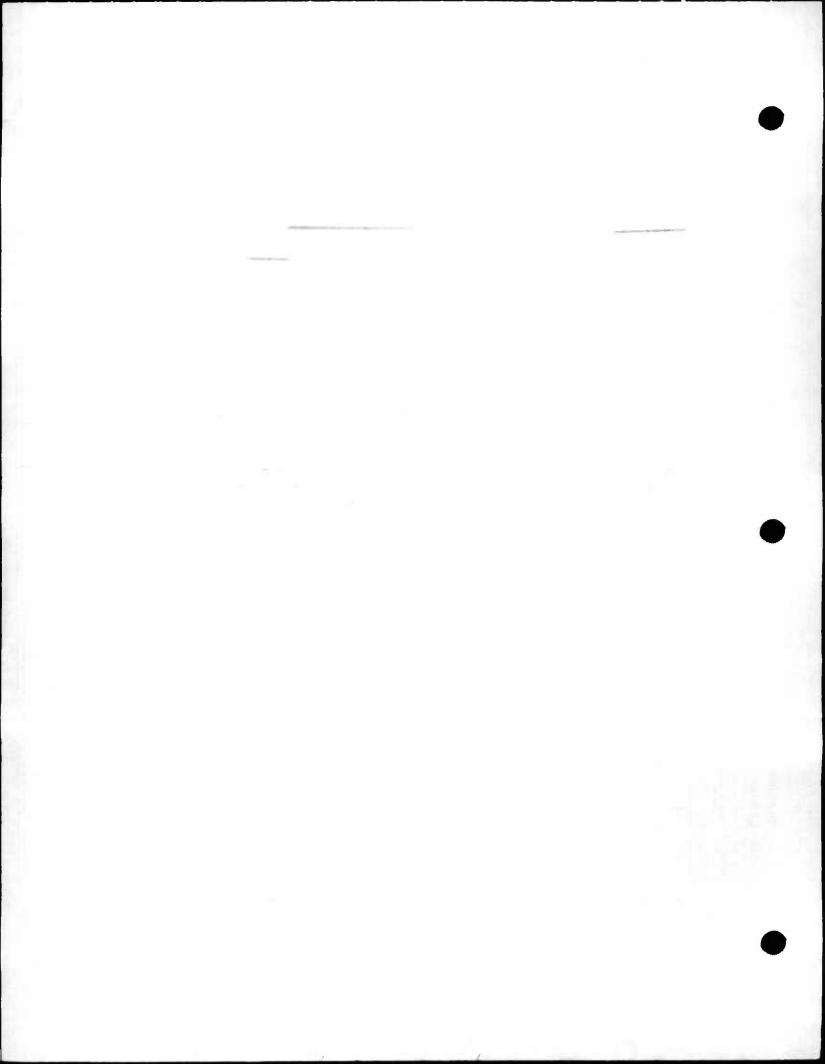


FOR

DIVISION OF VITAL RECORDS P.O. BOX 68760

		1 - STATE REGISTRAR	OIME OF MAIN	CE	RTIF	ICATE (OF DEATH	MICHIA	REG.			
		1. DECEDENT'S NAME (First, Middle, Last)						2. DAT	E OF DEAT	H	YEAR	3. TIME OF DEATH
		WILLIAM		_		NBURY		JU				20:47 P M
10		4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	E (In yrs. lest	birthday) YRS.	MONTHS DA	AR IF UNDER 24 HRS	(0.4-	OF BIRTH		8. BIRTHPI Country)	LACE (State or Foreign
2, 3 should	СТОВ	99. FACILITY NAME (If not institution, give et	Description of the second				WN OR LOCATION OF	DEATH		9c. COUN	ITY OF DEA	ATH
Pages 1,	뿐	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	,		10c. CIT	Y, TOWN OR L					1	IOd. INSIDE CITY LIMITS?
permit.	AAL DI	10e. STREET AND NUMBER					101. ZIP CODE			10g. CITI		AT COUNTRY?
physician. burial-transit	FUNER	11. MARITAL STATUS	12. WAS DECEDENT EVER				DECENDENT OF HISP s, specify Cuban, Mexi				14. RACE -	- American Indian, White, etc.
anding physical as the burial	BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR				YES 2 NO Spe		riscall, etc.	.,		White
al or atte	LETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)		(Gh	re kind of	work done during retired.)	PATION g most of working	18	b. KIND OF	BUSINESS/IND	USTRY	
he hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)				_						
3 4 4	BE CC	IT. PAINER S NAME (PISI, MIDDIN, LOSI)		_			18. MOTHER'S I	NAME (First,	Middle, Ma	iden Sumame)		
e 5 should a notified	10	19e. INFORMANT'S NAME (Type/Print)		19b.	. MAILING	ADDRESS (St	eet and Number or Run	al Route Nur	nber, City or	Town, State, Zip	Code)	
hours after death. Page 6 may be ed in by the funeral director, page or removal. medical examiner must be re		20a. METHOD OF DISPOSITION 1							aty or Town	n, State		
death. Pag tuneral dir i. examiner		State Anatomy Board-655 W. Baltimore Stree Rm. 8026-Baltimore, Maryland 21201-1559										ore Street
rs after don't by the fremoval.		willing /	Michelle			Rm.B	026-Balti	more	Mar	yland	2120	1-1559
24 hours afte filled in by th on, or remov		23. PART i. Enter the diseases, or c shock, or heart fallure. I IMMEDIATE CAUSE (Final	Dimplications thet caus List only one cause on	each line.	ith. Do i	not enter the	mode of dying, su	uch as car	diac or re	espiratory arm	eat,	Approximate interval Between Onset and Death
within pietely cremati		disease or condition resulting in death)	Arteriose DUE TO (OR AS				iovascu]	lar I	Dise	ase		
and and bur	NO	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
phy ne p	ERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
. 도 등 그 이	CERTI	resulting in deeth) LAST										
the d the d Me		PART li. Other significent conditions	contributing to death	but not re	sulting	in the under	iying cause given i	in Pert I.		AN AUTOPSY FORMED?		/ERE AUTOPSY FINDINGS
he law requires that thas been signed by e Dept. of Health an m 23 shows any	MEDICAL					_			1 🗆 YES	S 2 X NO	0	OMPLETION OF CAUSE OF DEATH? YES 2X NO
law red as been bept. of 23 sh		DID TOBACCO USE CONTR	IBUTE TO CAUSE	OF DEAT	H YE	S 🗆 NO	☐ UNCERTA	JN 🗆	dy	ration	-	_ 159 5V_ 110
	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	5-5-777		OTHER:	one)					
SICIAL Certifi the	HYS	1 YES 2 NO 27. MANNER OF DEATH	28e. DATE OF INJURY		DOA 28b. TIM		Home 5X Residence	_		W INJURY OCC	UBED	
DING PHYS After this death with s marked	ВУ Р	1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	,	INJ	M 1	WORK?		2 90 10			
CTOR: after	ETED	3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify)					office	28f. LO	or Town, St	eet end Number (tate)	or Rural Rou	ite Number,
	APL		CIAN: To the best of my kno									
	COMPL	2 X MEDICAL EXAMINER	a: On the basie of examinat	ion end/or in	rvestigatio	en, in my opinic	en, death occured at th	ne time, dat	end place	, end due to the	cause(e) e	nd manner ee stated.
TO THE HOSPI TO THE FUNEF be filed within	TO BE	296 ASIGNATURE AND TITLE GOVERNIFIER	I'rele				29c. LICENSE N					100th, Day, Year) 02,1995
	-	30. NAME AND ODDRESS OF PERSON WHO Margarita Kore					et, Balt	imoı	e, l	Maryla	ınd 2	21201
		31. DATE FILED (Month, Day, Year) 1995	30. REGISTRAR'S SIG							-		

	1	TEMS: 10a-10f, PER F.H.	FILM G-72	7 9/2	6/95 t	t.t							95	6	1138
		FOR 1 - STATE	STATE OF I	MARYL	AND / I	DEPAR	TMENT O	F HI	EALTH	AND I	MENTA	L HYGIEN	E		
		REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)			CE	RHE	ICATE ()F	DEA	ГН		REG. NO.			
		George C	annoi	n							MONT	OF DEATH		YEAR 3	LO SEA
		4. SOCIAL SECURITY NUMBER	5. SEX		'In yrs. last i	birthday)	IF UNDER 1 YE	EAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH		D. BIRTHPL	ACE (State or Foreign
1.00		_214-16-7433	1 2 M 2 🗆 F		76	YRS.	MONTHS DA	WB	HOURS	MIN.	8-18	5 - 1 8		Country)	Total or Foreign
3 should		9a. FACILITY NAME (If not institution, give s	treet and number)				9b. CITY, TO	WN OF	LOCATIO	ON OF DE			9c. COUN	TY OF DEA	ТН
2, 3 s	СТОВ	University of May	ruland				Ba	lti	more	2					
- -	딥					Ma CITY	r, TOWN OR LO	OCATI	OAL						
Pages	DIRE	MARYLAND CAROL					derick			EEDE	ERALSI	RURG			d. INSIDE CITY LIMITS?
permit.		10e. STREET AND NUMBER				1766		_	ZIP CODE				10a. CITIZ		T COUNTRY?
ist is	ER/	301 Smith Street							-4	2240	5 211	632		01 1111	
020 physician. burlai-transit	FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER I	U.S. ARM	ED	13. WAS	DECE	NDENT O	F HISPAN	IC ORIGIN	? (Specify Yes	or No—	4. RACE -	American Indian,
	ВУ Г	1 Never Married 2XX Married 3 Widowed 4 Divorced	IF YES, GIVE V)	If yes	YES 2	olfy Cuba 2)()(NO	n, Mexicer Specify	n, Puerto I	Rican, etc.)		Black, V Specify:	Black
	ED B	15. DECEDENT'S EQU	PATION	_									1		
	ETE	(Specify only highest grade	completed)		(Give	EOENT'S kind of w Oo NOT use	USUAL OCCUP rork done during e retired.)	PATION g most	of workin	g	16b	. KIND OF BUS	INESS/INDU	STRY	
ND 2 hospital	7	Elementary/Secondary (0-12) 8TH	College (1-4 or 5 -	+)		BORER	,,,,,,					PAIII TRV	DIANT		
the hospital or detached for u	COMPL	17. FATHER'S NAME (First, Middle, Last)								POULTRY PLANT IAME (First, Middle, Maiden Surname)					
ज दि 🗮	ш	WALTER CANNON									A JOH				
MAR retained 5 should notified	TO B	19a, INFORMANT'S NAME (Type/Print)			19b.	MAILING	ADDRESS (Str	reet and	d Number	or Rural R	loute Numb	ber, City or Town	n, State, Zip (Code)	
be re	F	MARIAN CANNON			102	SMIT	TH ST.	FE	DERA	LSBUR	G, MD	. 21632			
		20a, METHOD OF DISPOSITION 11. Buriel 2 Cremation 3 Remo	oval from State	20b	PLACE AN	ID DATE O	F DISPOSITION	N (Nam	e of		OAT		CATION — C		State
FIMOR Page 6 ma ral director, p		4 Donation 5 Other (Specify)	state r	emove	al MA	RYLAI	AD. AETER	RANS	CEM.	•	8/7/	95 BEUL	AH, ME	WENT.	NEWLY AND
AL FIR death. Pag tuneral di f. examiner		21. SIGNATURE OF FUNERAL SERVICE LIC	"//// Rona	ld W	ade,	ver.	-Sta	te te	Ana	E OF FAC	Bod	OX 1687	EACH!	NEKAL	Street
BAL ter death the fune wal.		Sinovo 110	ance	1			-1/11/1 a	13	120	BULL		- Autoric	greceree		04100559
n by remo		23. FART I. Enter the diseases, or o shock, or heart fellure.	emplications tha	t caused	the deat	th. Do n	ot anter tha	mod	a of dyl	ng, such	as card	flac or respin	ratory arre	et,	Approximata
		IMMEDIATE CAUSE (Fine)	C_{11}		ı 1	Λ	4								Interval Between Onset and Daath
within 24 opletely fill cremation,		disease or condition resulting in death)	subd	(V)C~	1 1	Hen	~Otto	8							
B 5 8			DUE TO	(OR AS A	CONSEQU	IENCE OF):								
Ox 687 e be executed sician and con nior to burial, traumatic e	CATION	Sequentielly list conditions,	DUE TO	(OR AS A	CONSEQU	IENCE OF	١٠								
ficate be physician ne prior t	CAT	cause. Enter UNDERLYING					,-								Í
certificate ding physi lygiene pri	RTIFI	CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS A	CONSEOU	ENCE OF):								
T = 8 = 0	ш	resulting in deeth) LAST	d												
	C	PART II. Other significent condition	e contributing to	death b	ut not res	sulting is	n the underl	lvina	Ceuse o	lven in i	Part i	24a, WAS AN	ALITOPEV	245 140	DE ALTOREY CINIDADO
law requires that the las been signed by the legit, and Market and Market and Market and Injury.	EDICAL							71119	oouse y	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Call I	PERFOR	MEO?	AV	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE
requires een signe of Health											-	1 TYES 2	NO	DF	DEATH?
w req been or, of	W .:	DID TOBACCO USE CONTR	RIBUTE TO CA	USE O	F DEATH	H YE	S I NO	П	UNC	ERTAIN	1	•		''	YES 2 TO
1 e = -	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					H (Check only o								
SICIAN: The certificate the State , or Item	YSI	1 YES 2 NO	HOSPITAL:	ER/Outp	atient 3	DOA	OTHER: 4 - Nursing I	Home	5 🗆 Rad	aldenca (8 🗆 Other	r (Specify)			
PHYSIC this cer with th	PH	27. MANNER OF DEATH 1. Natural 5 Pending	28s. OATE OF (Month, Di	INJURY ay, Year)		28b. TIME INJU	OF 28c.	INJUI WOR	RY AT		28d. DES	CRIBE HOW IN	JURY OCCU	REO	
DING PHYSI After this c death with	BY	2 Accident Investigation							S 2 [NO					
TTENDI TTENDI TTOR: A after d		3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE O building,	F INJURY atc. (Spec	— A1 home	e, farm, et	treet, factory, o	offica			281. LOCA City (ATION (Street as or Town, State)	nd Number o	Rural Rout	Number,
DR ATTENDING PHYSICIAN: DIRECTOR: After this certifications after death with the St. Item 28 Is marked, or It	ETEI	20. OFFICE						_				<u>-</u>			
	COMPL	(Check only CEHTIFYING PHYSIC													
THE HOSPITAL THE FUNERAL filed within 72 h	8	2 MEDICAL EXAMINER		штинитю	and/or inv	restigation	i, in my opinio	m, dea	ith occur	ed at the 1	lime, data	and place, and	due to the	cause(a) an	d manner as stated.
불분들은	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	1/21		M	D.			A I (NSE NUM	BER	-2814	29d. DATE	SIGNED (M	nth, Day, Year)
2 2 2 2	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	SE OF DE	TH (ITEM	27) (Tono	Print)	1	7V41	764.	JUM	2.18	- 7	1	7-1
		225GREEN ST.	RALTE	MOR	5 N	1) .	2/20	0 ,	17	Da.	G. C	. 77L	AKU	2	
		31. OATE FILED (Month, Day, Year)						_	1			117		ليد	
		AUG 1 1995	32. REGISTRA	4 10	v-Ras	1.11	1								
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ined by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

ould be detached for use as the burial-transit permit. Pages 1, 2, 3 should

FUNERAL

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COMPLETED

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notified at once.

other traumatic CERTIFICATION

MEDICAL

PHYSICIAN:

ВҰ

COMPLETED

BE 2 1 Netural
2 Accident

3 Sulcide

4 Homicid

29a. CERTIFIER

5 Pending

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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TO THE HDSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be reta	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 st be filed within 72 hours after death with the State Debt, of Heath, and Mental Hybiehe orior to busial, cremation, or namenal	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be not
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23039 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH Marci Glazer Crosby July 28, 1995 5:30 PM 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 1 🗌 M 2 🙀 212-52-1492 May 23, 1963 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Sinai Hospital Baltimore N/A 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore Baltimore 1 - YES 2 X NO 10e. STREET AND NUMBER 10f. ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? 2728 Quarry Heights Way 21209 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 TO NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced 1 TYES 2 TONO Specify: Specify: White 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY ntary/Secondary (0-12) College (1-4 or 5+) Law 5+ Attorney 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lowell Glazer Harriet Lazinsky 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2728 Quarry Heights Way, Baltimore, MD Robert J. Crosby 21209 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State 1. Burial 2 Cremation cometery, crematory or other place) Arlington(Chizuk Amuno) n 5 Cotte 7/30/95 Baltimore, MD 21. BIGNATURE OP 15 22. NAME AND ADDRESS OF FACILITY Sol Levinson & Bros. 6010 Reisterstown Rd, Baltimore,MD 21215 23 PART I. Enter the diseases, shock, or heer self or complications that ceused the death. Do not enter the mode of dying, auch as cerdiec or respiratory arrest. shock, or ure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Geath disease or condition ercutomistoh resulting in death) Leele DUE TO (OR AS & CONSEQUENCE OF): Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING Lan alie CAUSE (Diseese or Injury that initiated events resulting in deeth) LAST NCE OF) 0

	None,		-
DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEATH	YES INO W UNCERTAIN	
5. WAS CASE REFERRED TO MEDICAL	28. PLACE O	F DEATH (Check only one)	_
EXAMINER?	HOSPITAL:	OTHER:	_

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 1 | YES 2 | NO

DID TOBACCO USE CONT	RIBUTE TO CAUSE OF DEATH	YES NO UNCERTAIN								
25. WAS CASE REFERRED TO MEDICAL	28. PLACE OF DEATH (Check only one)									
1 YES 2 NO	HOSPITAL: 1 A Inpetient 2 ER/Outpetient 3 1	OTHER: OOA 4 Nursing Home 5 Residence 8 0								
27. MANNER OF DEATH		IN TIME OF THE BUILDING								

28a. DATE OF INJURY

ther (Specify) 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED

" 1 TES 2 NO	
28s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify)	261. LOCATION (Street and Number or Rural Route Number, City or Town, State)
 Transfers (Institute of the Institute of	

2	MEDICAL EXAMINER: On	the beals of examination and/or investigation, in my opinion, death occurs at the time, data and place, and due to the cause(s) and manner as stated
d a	NO TITLE DE CEPTIEIEN	

29b. SIGNATURE AND TITLE OF CERTIFIER	houmD. F.AC.S.	Jac. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

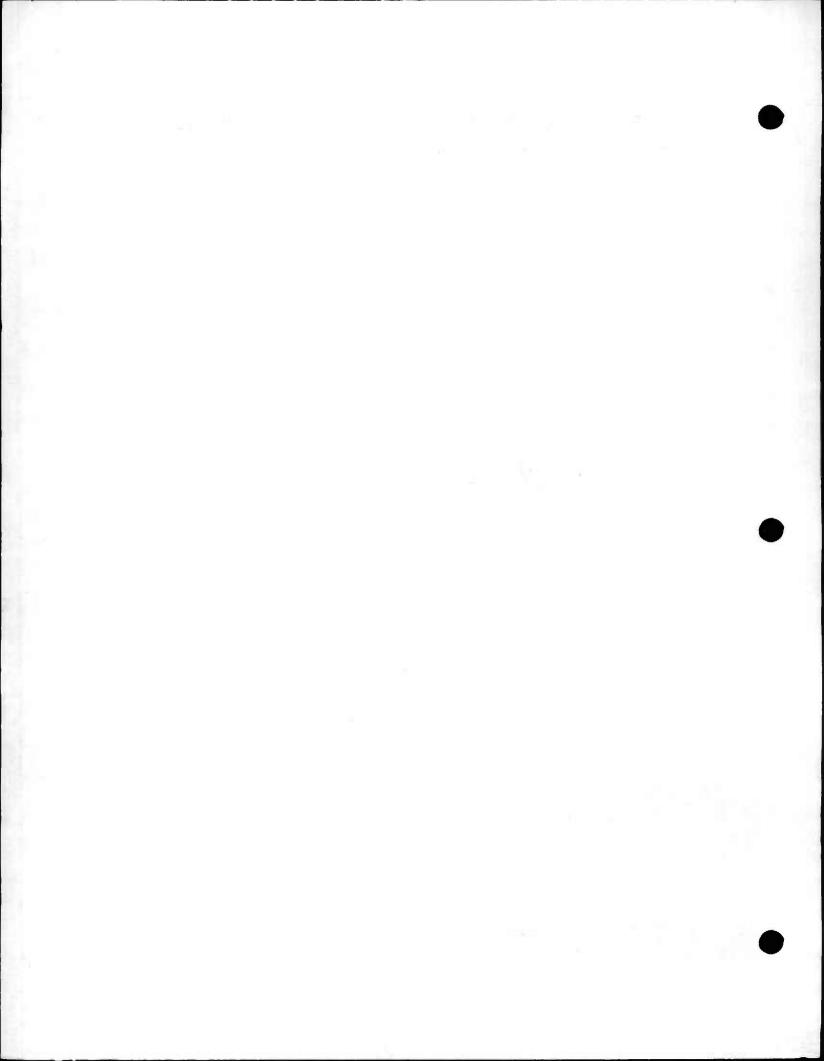
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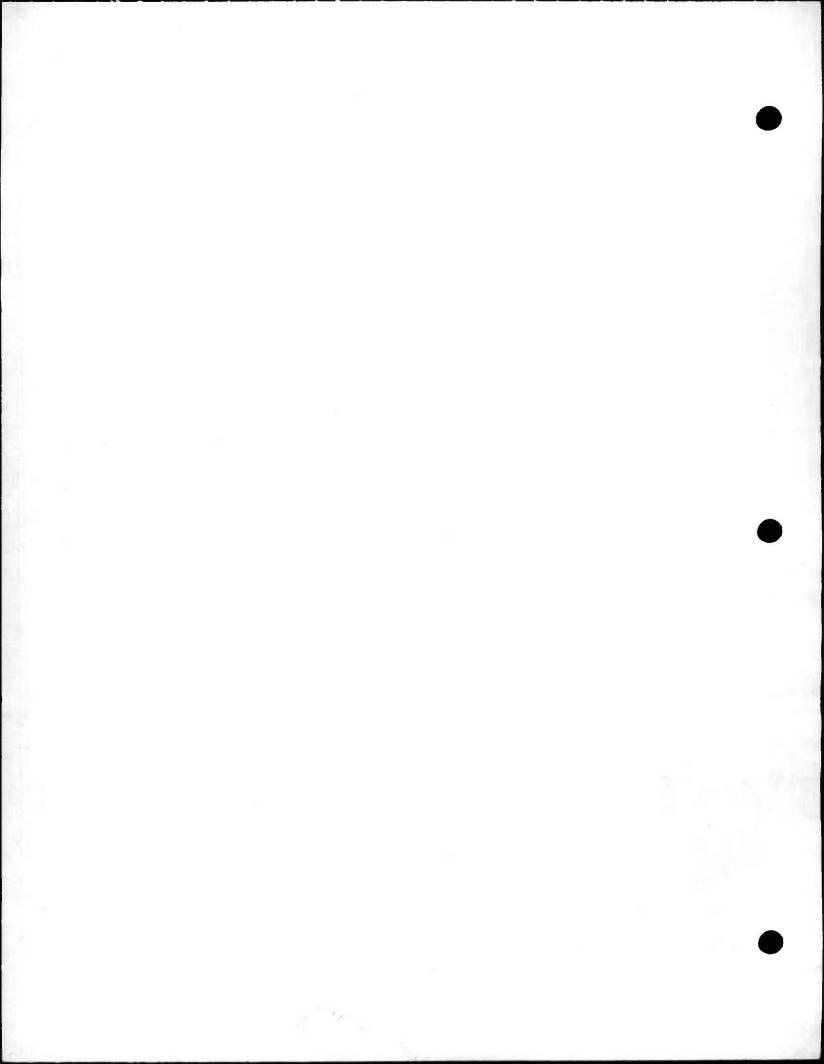
		REGISTRAR			ICATE O		4.3	EG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF C		3. TIME OF DEATH
		FREDERICK	H CO	OK, JR.			MONTH		YEAR 1217 A
		4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)	IF UNDER 1 YEAR	R IF UNDER 24 HRS.	7. DATE OF B	22 9	1 1 1 1 1 1 1 1
		E76 22 5362			MONTHS DAY		(Month, Day	r, Year)	B. BIRTHPLACE (State or Foreign Country)
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3 should	-	9e. FACILITY NAME (If not institution, give			1	N OR LOCATION OF D	EATH	9c. COUNT	TY OF DEATH
permit, Pages 1, 2, 3	DIRECTOR	BALTIMORE VA	mc		BA	TIMORE		Balti	more
	5	RESIDENCE OF DECEDENT						34202	moze
	1 22	10e. STATE 10b. COUNT	Υ	10c. CIT	Y, TOWN OR LO	CATION			10d. INSIDE CITY LIMITS?
.f.	1	Virginia Sta	afford	Sta	fford				1 YES 2 X NO
Lie0	A P	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZI	EN OF WHAT COUNTRY?
- T S	FUNER	#2 Hawthorne Cour	· +			2255	/.	IICA	
Cian. I-trar	=	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN II S ARMED	12 WAS D	ECENDENT OF HISPA		USA	
215-0020 attending physician. se as the burial-transit		1 Never Married 2 Married	FORCES? 1 TYPE	S 2 NO	Il yes,	specify Cuben, Mexic	an, Puerto Rican	, atc.)	 RACE — Americen Indian, Black, White, atc.
the the	B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES	1 🗆 Y	ES 2 X NO Speci	fy:		Specify: White
as as	ED	15. DECEDENT'S EDU	CATION	Las properties			1		
2121	ETE	(Specify only highest grade	completed)	16a. DECEDENT'S	USUAL OCCUPA work done during se retired.)	MOST of working	16b. KIN	D OF BUSINESS/INDU	STRY
2 paragraph 2	2	Elementary/Secondary (0-12)	College (1-4 or 5 +)						
Se iche	ž	12		Paint	er		S	elf-Emplo	yed
AN the hox detach	COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N	AME (First, Middle	, Meiden Surname)	
MARYLAND 2 retained by the hospital 5 should be detached for notified at once.	BE (Frederick H. Cook	. Sr.			Mildre	ed Walt	ers	
MAR retained 5 should notified		19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stree			ity or Town, State, Zip C	Corde
	2	Lisa Morgan							*
E, y be sage		20a. METHOD OF DISPOSITION						, Va. 225	
ORI e 6 ma) ector, p		1 Buriel 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	oval from State Co	Ob. PLACE AND DATE (emetery, crematory or or		(Name of	DATE	20c. LOCATION — CH	
BALTIMORE, s after death. Page 6 may be by the funeral director, page removal.				Metropoli	tan Cre	matory	7/24	Alexandri	a, Va.
		21, SIGNATURE OF FUNERAL SERVICE LI	. 1.1			AND ADDRESS OF F			
		Dement /	Muers						HOME, INC.
the the loval		1// 1000			1/1	W. Maple	Ave.,	Vienna, V	a. 22180
w		23. PART I. Enter the diseases, or ahock, or heart failure.	Complications that cause List only one cause on	ed the death. Do n	not entar tha n	node of dying, aud	ch as cardiac	or reapiretory arres	
		IMMEDIATE CAUSE (Final							Interval Between
· · ·		disease or condition		A CONSEQUENCE OF	Lupm	14			and the second second
1760: ted within completely ial, cremati		resulting in death)	DUE TO (OR AS	A CONSEQUENCE OF	Pi:	16			- mylenn
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OX 68 e be execut sician and c infor to buris traumatic	CERTIFICATION	Sequentially list conditions,	b. DUE TO JOB AC	A CONSEQUENCE OF					
De pe	A	if any, leading to immediate cause. Enter UNDERLYING	DOE TO (ON AS	A CONSEQUENCE OF	r):				
四 音	2	CAUSE (Disease or injury C.							
P.O. Eth certifical the certifical thygiene I Hygiene or other	1	that initisted events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST							
O = 5 - 5	띪	reacting in death, EAST	d						
S, F e death he atte Mental jury, C		DART II Other elegitions and disc	and the state of the state of						
나 은 무지트	EDICAL	PART II. Other algnificant condition	a contributing to death	but not resulting i	In the underly	ing cause given in	Part I. 24a.	WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
COR ires that signed by teatth and	용							YES 2 THO	COMPLETION OF CAUSE
= 0 1 3 1								,	OF DEATH?
St. of Be a	-	DID TOBACCO USE CONT	DIRLITE TO CALISE	DE DEATH VE	ON FE 2	LINICEDTAL			1 VES 2 NO
13 e s e C	PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL	KIBOTE TO CAUSE (26. PLACE OF DEAT	_		ИП		
N: The licate h State C	$\overline{\Omega}$	EXAMINER?	HOSPITAL:		OTHER:	9)			
F VIT.	ΥS	1 YES 2 NO	15 Inpatient 2 ER/Ou	tpatient 3 DOA		ome 5 🗆 Residence	8 Other (Spe	octfy)	
PHYSIC this ce with t	H	27. MANNER OF DEATH	(Month, Day, Year)			NJURY AT YORK?	28d. DESCRIB	E HOW INJURY OCCU	RED
	ВУ	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO			
ION NDING F Harry death	- 11	3 Suicide 8 Could not be	28e. PLACE OF INJUR	IY — At home, larm, s	treet, factory, of	fice	281. LOCATION	(Street and Number or	Rural Route Number
DIVISION OF VITA OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate he hours after death with the State D item 28 is marked, or item it	뎶	4 Homicide datarmined	building, atc. (Sp.	ecify)			City or Tow	vn, State)	
DIV OR A DIREC hours	COMPLET	29a. CERTIFIER							
2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	집	(Check only DELEHTIFTING PHYS	CIAN: To the best of my kno						
ER FR	6	one) 2 MEDICAL EXAMINE	R: On the basis of axaminati	on end/or investigation	n, in my opinion,	death occured at the	lime, date end	place, and due to the	couse(e) end menner ee stated.
(0 = = =		29b. SIGNATURE AND TITLE OF CERTIFIE							
FUN WITH	ш	0/	P- No			29c. LICENSE NUI		29d. DATE S	SIGNED (Month, Day, Year)
THE HOS THE FUNI filed withi	00	1/ / .97				1 007	123		7/22/95
TO THE HOSPITAL (TO THE FUNERAL D DE filed within 72 he IMPORTANT: If It	0 B	Kenneh				1			1/10/73
TO THE HOS TO THE FUNI be filed withi	ω	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF D						
TO THE HOS TO THE FUNI Be filed withi	ω		O COMPLETED CAUSE OF D					E ST RAIT	IM WEE MO ZIEGO
TO THE HOS TO THE FUNI Be filed withi	ω		O COMPLETED CAUSE OF D	LAND DEPT				E ST RAIT	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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BALTIMORE, MARYLAND 21215-0020	house ofter death Date & may be enterious by the breezest or secondar at all a
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			CERTIF	ICATE O	FDEATH	REG. NO	D.				
	1. DECEDENT'S NAME (First, Middle, Last)	A .		Mon		Jaly	DAY YEA	18:40			
	4. SOCIAL SECURITY NUMBER 056 03 9397 9a. FACILITY NAME (If not institution, give	1 📉 M 2 🗆 F	GE (In yrs. lest birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) July 12,	1910 Ne				
ECTOR	Washington Advent		1		or location of de	ЕАТН	Montgomery				
DIREC	10e. STATE 10b. COUNT	itgomery		y, town on Loc lver Sp		10d. INSIDE CITY LIMITS? 1 YES 2 X					
	100. STREET AND NUMBER 10802 Margate Roa				101. ZIP CODE 20901						
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 M Widowed 4 Divorced	12. WAS DECEDENT SVE FORCES? 1 (A) Y IF YES, GIVE WAR OF	ER IN U.S. ARMED ES 2 NO R DATES	If yes,	ECENDENT OF HISPAN	SPANIC ORIGIN? (Specify Yea or No- exican, Puerto Rican, etc.) 14. RACE — American Black, White, atc. Specify: White 16b. KIND OF BUSINESS/INDUSTRY BOOK Manufacturing Company					
PLETED	15. DECEDENT'S EDI (Specify only highest grade Elementary/Secondery (0-12) 12		16a. DECEDENT'S (Give kind of life. Do NOT u	work done during i	TION nost of working						
₩ I	17. FATHER'S NAME (First, Middle, Last) John Cullom				Elizabe	MOTHER'S NAME (First, Middle, Maiden Surname) Lizabeth Armstrong					
T of	190. INFORMANT'S NAME (Typo/Print) Barbara Cullom					Poute Number, City or To					
must be	20e. METHOD OF DISPOSITION 1	noval from State	206. PLACE AND DATE CORPUS CONTROL OF CONTROL NOT THE Th	OF DISPOSITION (Name of	DATE 20c. L	OCATION — City o				
examiner	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE / Have	ma	Aff			vices				
mental rygens pro to obtain, contention, or stringer lightly, or other traumatic event, the medical CERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	bDUE TO (OR A	A CONSEQUENCE O	F):	Se d	· eart	Die	Interval Between Onset and De			
m 23 shows any injury,	PART II. Other significent condition	ns contributing to deat	h but not resulting		ng ceuse given in	PERFO	PERFORMEO? 1 YES 2 NO COMPLETION OF CAUSE DF DEATH?				
SICIAN: P	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	26. PLACE DF DEA	TH (Check only on)			1 YES 2 NO			
8 is marked, o ED BY PHY	27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined	28e. DATE OF INJUF (Month, Day, Yea	PRY — At home, farm, specify)	E OF 28c. II		8 ☐ Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State	and Number or Rui	al Route Number,			
= 5		ICIAN: To the best of my kn	owledge, death occurre	ed at the time, da	te and place, and due	to the cause(a) end ma	nner as stated.	e(a) and manner as stated.			
IMPORTANT	29b. SIGNATURE AND TITLE OF CERTIFIES	Soul	~		29c. LICENSE NUM	IBER TYL	29d. DATE SIGN	ED (Month, Day, Year)			
4 D E	30. NAME AND ADDRESS OF PERSON WH							1 1			



death. Page 6 may be retained by the hospital or attending physician. Inneral director, page 5 should be detached for use as the burial-transit **BALTIMORE, MARYLAND 21215-0020**

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DIVIDIGITATION OF ALL PECCHOS, P.O. DOA 00/00	certificate	
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4	HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours a	

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEOENT'S NAME (First, Middle, Last) HARVEY ELRIDGE 2. DATE OF OEATH 3. TIME OF DEATH DENMARK 1995 JÜÜLY 28 JR. 7:19 DM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DEC . 23 1 XM 2 - F 216 07 7760 80 1914 MÄERYLAND Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH DIRECTOR MARYLAND GENERAL HOSPITAL N/A BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/ABALTIMORE YES 2 NO permit. FUNERAL 10s. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 1000 N. GILMOR STREET 21217 U.S. OF A. 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 \square NO IF YES, GIVE WAR OR DATES 1943 - 1946 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, alc. 1 Never Married 2 Married Specify: BLACK BY 1 TYES 2 NO Specify: Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) CLERK condary (0-12) College (1-4 or 5+) YEARS 12TH EARNINGS INVESTIGATION SOCIAL SECURITY 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumame) BESSIE NEAL HARRIS 7 HARVEY ELRIDGE DENMARK, SR. 띪 notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 1645 WINFORD RD. BALTO., MD. 21239 MRS CHARLOTTE Ε. DUDLEY Pe 20a METHOO OF DISPOSITION

1 Burlal 2 Cremetion 3 Res 20b. PLACE AND DATE OF DISPOSITION (Name of 3/95 OATE 20c. LOCATION — City or Town, State BALTO must GARRISON FOREST VET. CEM. ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD. CO. LEWIS T. GWYNN 22. NAME AND AGRESS OF FACILITY examiner LEWIS T. GWYNN FUNERAL HOME 21215 4517 PARK HEIGHTS AVE. BALTO., MD. rs after de n by the fi removal. medical 23. PART I. Enter the diseases, or complications that clused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one cause on each line. 0 Interval Between IMMEDIATE CAUSE (Finsi Onset and Death the cremation, disease or condition resulting in death) pletely POST OPERATIVE CARDIAC ARRYTHMIA event, 30 minutes DUE TO (OR AS A CONSEQUENCE OF): and com burial, o traumatic CERTIFICATION CLOSURE OF LEFT HIP ULCER WITH FLAP days Sequentially list conditions, 2 DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING prior CAUSE (Diseese or Injury other the attending phy I Mental Hygiene I DUE TO (OR AS A CONSEQUENCE OF). thet initieted events resulting in death) LAST 6 injury, PART II. Other significant conditions contributing to death but not reaulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS a ba AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PULMONERY HYPERTENSION PERFORMEO? shows any 1 - YES 2 X NO RENAL INSUFFICIENCY , CHRONIC HEART FAILURE 1 TES 2 NO o DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: State Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) certificate I HOSPITAL: OTHER: 1 TES 2 NO [N Inpatient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28b. TIME OF 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DEŞCRIBE HOW INJURY OCCURED TO THE HOSPITAL DR ATTENDING PHYSIN TO THE FUNERAL DIRECTOR: After this ce be filed within 72 hours after death with tIMPORTANT: If item 28 is marked, **XXNatural** 5 Pending В 1 YES 2 NO Investigation 2 Accident 3 Sulcide 26a. PLACE OF INJURY — At home, ferm, streel, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide determined 29a. CERTIFIER 1 KC CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER amon 89234 MD 28 95 2

c/o MARYLAND GENERAL HOSPITAL

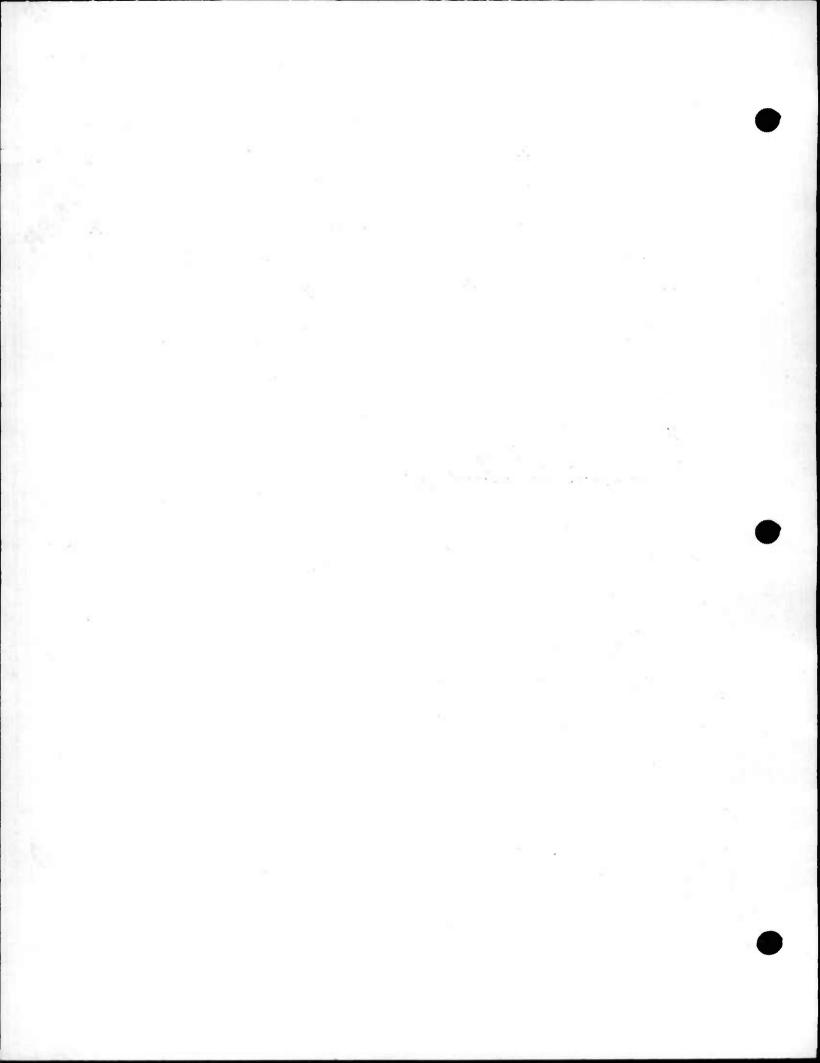
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D.

THE OFFICE STRUCTURE

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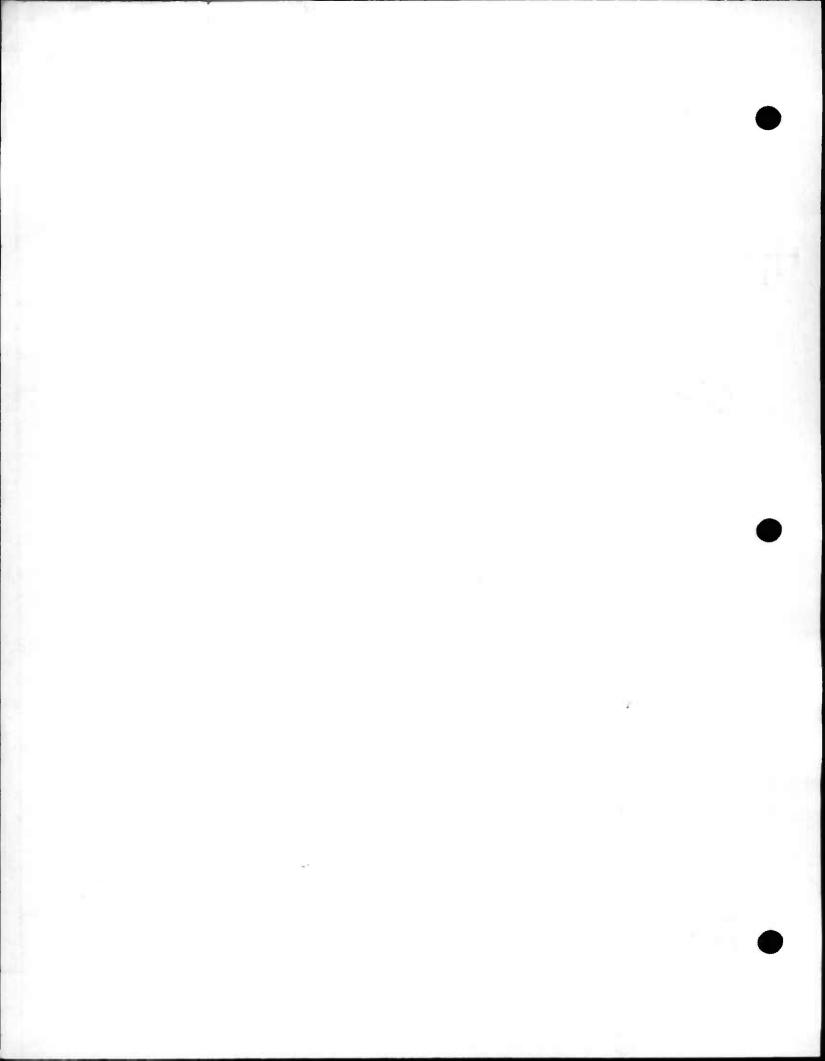


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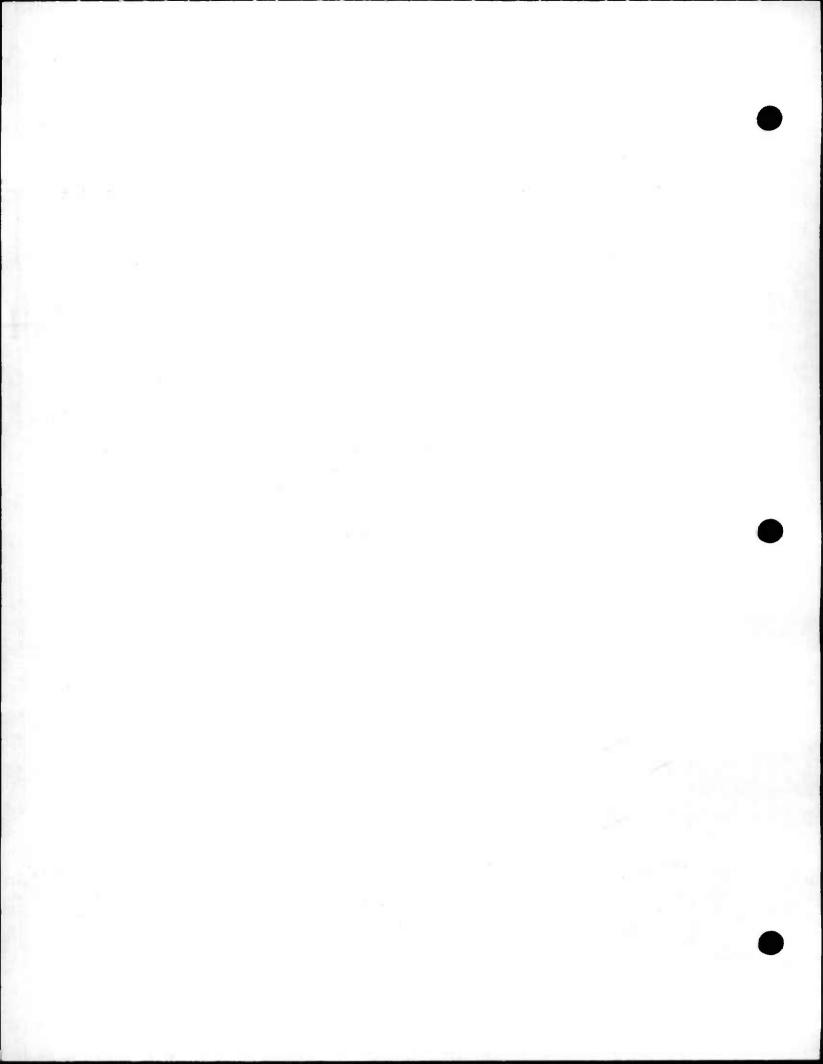
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	TO THE HDSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the In	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detact
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FOR									
1 . STATE	STATE OF MAR				MENTAL HYGIEN	IE			
REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last		CERTI	FICATE C	F DEATH	REG. NO),			
WILL AND A	F DOOLE	-61				-	YEAR 3. TIME OF DEATH		
4. SOCIAL SECURITY NUMBER	-	AGE (In yrs. last birthday) IF UNDER 1 YEA	IF UNDER 24 HRS,	7. DATE OF BIRTH	- I	9.17 0		
08 11 03 632	1 № M 2 🗆 F	83 YRS.	MONTHS DAY		(Month, Day, Year)	1	New York		
9a. FACILITY NAME (If not institution, give	street and number)			N OR LOCATION OF D	EATH		Y OF DEATH		
RESIDENCE OF DECEDENT 100. STATE 100. COUN Maryland Balt	CUTAN HOS	SPITAL	BAL	MONE	MD	U	G4		
RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	10b. COUNTY								
Maryland Balt	imore Count	y F			LIMITS?				
100. STREET AND NUMBER					10g. CITIZE	N OF WHAT COUNTRY?			
4139 Lincoln Av				21236			USA		
11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVE FORCES? 1 X	YES 2 NO	13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	or No- 1	4. RACE — American Indian, Black, White, etc.		
3 💢 Widowed 4 🗌 Divorced	WW 2	OR DATES		YES 2 NO Speci		1	Specify: White		
15. OECEDENT'S ED	UCATION	18a. OECEDENT	S USUAL OCCUP	ATION	16b. KIND OF BU	SINESS/INDUS			
Elementery/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT	f work done during use retired.)	most of working					
Elementery/Secondery (0-12) 3 Years 17. FATHER'S NAME (First, Middle, Last)		Truck	Driver		Sugar	Refini	ng Factory		
17. FATHER'S NAME (First, Middle, Last)		D1			AME (First, Middle, Melden	Sumeme)			
Daniel 19a. INFORMANT'S NAME (Type/Print)		Dooley			Ann Rice				
0	C				Route Number, City or Tow				
Mr. Mark Andrew 20a. METHOD OF DISPOSITION		20b. PLACE AND OAT			OATE 20c. LO		land 21236		
1 Donation 5 Other (Specify)	movel from State	comotoni oromatoni ni	other placel		1		nd, New York		
21. SIGNATURE OF FUNERAL SERVICE L	CENSEE	Carverto	22. NAME	ANO ADDRESS OF F	ICITITA ETAOLT LEOT	g_TST8	nd, New York		
Martin D. La	wson		Mit	chell-Wie	defeld Home	е	aryland 21212		
resulting in death)			*	EAU IIPT			Onset and Deat		
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in deeth) LAST	b. CONG OUE TO (OR A		YEART OF): AL FA	FAILURE MLUR E			Onset and Deat		
PART II. Other eignificant condition PART II. Other eignificant condition The property of th	c. ACUI DUE TO (OR A d.	AS A CONSEQUENCE	HEMT OF): AL FA OF):				Onset and Deat 4 dayS 10 dayS 4 dayS 4 dayS 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
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Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST PART II. Other eignificant conditions. DID TOBACCO USE CONTEST OF STATE	DUE TO (OR A C. ACUT DUE TO (OR A d. DUE TO (OR A DUE	AS A CONSEQUENCE AS A CONSEQUENCE THE PROPERTY 26. PLACE OF DE Outpstient 3 DOA RY 29b. Till URY — At homa, farm Specify) DURY — At homa, farm Specify desth occur estion end/or investigate	ES NO. ATH (Check only or OTHER: 4 No. Street, factory, or red at the time, d on, in my opinion	UNCERTAINE) UNCERTAINE) TOTAL TOTA	Part I. 24a. WAS AN PERFOR 1 VES 2 N Other (Specify) 28d. DESCRIBE HOW II 28f. LOCATION (Street a City or Town, State) to the cause(s) and mar	NJURY OCCUR and Number or	Onset and Deat 4 dayS 10 dayS 4 dayS 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO REO Rural Route Number,		
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST PART II. Other eignificant conditions. DID TOBACCO USE CONTEXT OF STATE	DUE TO (OR A C. ACUT DUE TO (OR A d. DUE TO (OR A DUE	AS A CONSEQUENCE AS A CONSEQUENCE THE PROPERTY 26. PLACE OF DE Outpstient 3 DOA RY 29b. Till URY — At homa, farm Specify) DURY — At homa, farm Specify desth occur estion end/or investigate	ES NO. ATH (Check only or other)	UNCERTAINE) Ome 5 Residence INJURY AT WORK? YES 2 NO Iffice ste and place, and due to, death occured at the	Part I. 24a. WAS AN PERFOR 1 VES 2 N Other (Specify) 28d. DESCRIBE HOW II 28f. LOCATION (Street a City or Town, State) to the cause(s) and mar	NJURY OCCUR and Number or	Onset and Deat 4 dayS 10 dayS 4 dayS 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO REO Rural Route Number,		



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P.O.
RECORDS,
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OF V
DIVISION

		1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		ITAL HYGIENE REG. NO.		
		1. DECEOENT'S NAME (First, MIDDIO, Last) MARGARET	FCKELS	S		-	DATE OF DEATH DAY	3. TIME OF DEATH	
2		4. SOCIAL SECURITY NUMBER 217 26 8212	1 □ M 2 🔀 F 9	(In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN	ATE OF BIRTH Month, Day, Year) Ag. 30, 1903	8. BIRTHPLACE (State or Foreign Country) Hungary	
. 2, 3 should	стов	NORTH ALUD	itreet and number) EL Hospid	tal	Sh. CITY, TOWN	OR LOCATION OF DEATH	9c. CO	ANNE ARUNDEL	
t. Pages 1,	DIREC	10e. STATE 10b. COUNT	ne Arundel		y, town on Locat	TION		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
n. Insit permit.	ERAL	100. STREET AND NUMBER 267 Hickory Po:	int Road			21122	10	ITIZEN OF WHAT COUNTRY? U.S.A.	
5-0020 nding physician. is the butal-transit	BY FUNER	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 XNO	If yes, sp		RIGIN? (Specify Yee or No-		
2121 tal or atte	LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION o completed) College (1-4 or 5+)	(Give kind of v life. Do NOT us	41(32) - 47	ON set of working	16b. KIND OF BUSINESS/IF		
d ed e	COMPL	4th 17. FATHER'S NAME (First, Middle, Last)	Anton Kovac	Home M	aker	. '	Own Home irst, Middle, Maiden Sumame)		
retained by the 5 should be notified at		19a. INFORMANT'S NAME (Type/Print)			AODRESS (Street a	Eliza Ind Number or Rural Route	Number, City or Town, State, 2	known) Zip Code)	
do as	۴	Margaret Oltmar		267 Hi		oint Road		Maryland 21122	
E 9 5 -		1 1 Buriel 2 □ Cremetion 3 □ Rem 4 □ Donation 5 □ Other (Specify)	coval from State	etery cremetary or of	n Memori	al Park 7	/31 Glen B	- City or Town, State	
₹ 8 2 . 3		21. SIGNATURE OF FUNERAL SERVICE LI	and &	onie	George	e J. Gonce	Funeral Hom Baltimor	ne P.A.	
z4 hours aff y filled in by tion, or remo		23. PART I. Enter the diseases, or ehock, or heart feliure. IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	e. Adeuo	ech line.	ot anter tha mo	da of dying, such as	cardiac or reapiratory a	Approximate interval Between Onset and Death	
th certificate be executed physician and I Hygiene prior to bur or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	oue to (or as a consequence of):						
w requires that the death been signed by the attentor. of Heath and Mental shows any injury, of	MEDICAL (PART II. Other eignificent condition	e contributing to deeth bu	ut not resulting i	n the underlying	g cause given in Part	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
has De De	AN	DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		F DEATH YE	H (Check only one)	K UNCERTAIN [1		
PHYSICIAN: The this certificate with the State rked, or Item	PHYSICI	1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL; Inpetient 2 ER/Outpet 28a. OATE OF INJURY	etlent 3 DOA		e 5 Residence 8 0	Other (Specify) DESCRIBE HOW INJURY OF	COURTS	
	B	1 Natural 5 Pending Pending Investigation	(Month, Day, Year) 280. PLACE OF INJURY	INJ	M 1 7	RK? (ES 2 NO			
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED	3 Suicide & Could not be 4 Homicide determined	building, atc. (Speci	- At home, ferm, a	treet, factory, office		LOCATION (Street and Number City or Town, State)	er or Rural Route Number,	
4 4 A =	COMPLI	One) 2 MEDICAL EXAMINE						ated. the cause(e) and manner se stated.	
TO THE HOSPI TO THE FUNER be filed within	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIES 30. NAME AND ADDRESS OF PERSON WITH	MD			D468	29d. DA	TE SIGNED (Month, Day, Year) ULY 28, 1995	
6		YURI CANI 31. DATE FILEO (Month, Day, Year)	ALE 120	6 HA1	2+ley	cincl	E#543	4115 UM	
_		BUCO 1 1000	STATE OF THE STATE	mandall.	1				



2:40pm

Approximate interval Batwe **Onset and Death**

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

2122

REG. NO.

2. DATE OF DEATH

		4. SOCIAL SECURITY NUMBER 074 16 6555	5. SEX 1 ₩ 2 □ F	6. AGE (In yrs. 75	lest birthday) YRS.	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF (Month, D	ny, Year)		Country)	ACE (State or Foreign
pine		9a. FACILITY NAME (If not institution, give				Sh CITY	TOWAN C	OR LOCATIO	ON OF DE	01 01	20		Italy TY OF DEA	
2, 3 should	TOR	Medridge Nurs						ille						
permit. Pages 1.	DIRECTOR	10a. STATE 10b. COUN	10b. COUNTY 10c. CITY, TOWN OR LOCATION N/A Paltimoso							0d. INSIDE CITY LIMITS? X YES 2 \(\) NO				
.ps	FUNERAL	100. STREET AND NUMBER 344 Hornel St	treet				101	2122						AT COUNTRY?
21215-0020 I or attending physician. for use as the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE N	YES 2	ARMED NO		If yes, sp	ecify Cubar	n, Mexicen	ANIC ORIGIN? (Specify Yes or No— 14. RACE — America Black, White, sto Specify: White				
2 5	APLETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12) 12	UCATION de completed) College (1-4 or 5	+)	OECEDENT'S (Give kind of life. Do NOT u	work done se retired.)	during mo	ON ist of workin	166. KIND OF BUSINESS/INDUSTRY Crown, Cork, Sea					
Z 2 2 2	i	17. FATNER'S NAME (First, Middle, Last) Frank Eufemia								er's NAME (First, Middle, Meiden Sumeme) oncetta Bonincontri				
MA retain 5 sho	TO B	190. INFORMANT'S NAME (Type/Print) Frank S. Eufe	mia		196. MAILING 1516 (ADDRESS	s (Street a	Cour	or Rural A	Rural Route Number, City or Town, Stete, Zip Code) Rosedale, Md. 21237				
m > 2 =		20e. METNOD OF DISPOSITION 1- Burlel 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	cemetary,	ceand date crematory or o	ther place)			7–31	DATE 20c. LOCATION — City or Town, State -31+95 Eastwood, Md.				
0 = 0		21. SIGNATURE OF FUNERAL SERVICE I	D. Bel	ke.		22. Ch	name an	D ADDRES	zei		Son	Inc.		
P.O. BOX 68760, the certificate be executed within cours the certificate be executed within course lending physician and completely filled in bit lygiene prior to burial, cremation, or red or other traumatic event; the medi	ERTIFICATION	23. PART I. Enter the diseases, or ahock, or heart failure immediate cause (Final disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	a. Source To Due To C.	OF AS A CON	SEQUENCE O	The	ca cal	to dyl	ng, auch	y du	or reapli	ratory arre	at,	Approximate interval Batwe Onset and De
ECORDS quires that the d signed by the Health and Mei	MEDICAL	PART II. Other algnificant condition	one contributing to	death but no	ot resulting	in the ur	nderlying	PERFORMED? 1 VES 2 NO OF DEATN?					TERE AUTOPSY FINDIN MAILABLE PRIOR TO OMPLETION OF CAUSE F DEATN? YES 2 NO	
ITAL R. 4: The law recate has been state Dept. of Item 23 sh	ᅙ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	1 5010 1 11		OTHE	R:			ck only one)				
VISION OF VITATIONS PHYSICIAN: ECTOR: After this certificals after death with the Signatured. Or 18.		1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation	1 inpatient 2 28e. DATE OF (Month, E	INJURY	28b. TIN	_	26c. INJ WO			26d. DESCRIBE NOW INJURY OCCURED				
DIVISION OR ATTENDING P DIRECTOR: After t hours after death tem 28 is mark	TED	3 Suicide 6 Could not be 4 Nomicide determined	26a. PLACE C	OF INJURY — At , etc. (Specify)	t home, farm,	street, fect	lory, offic			26f. LOCATIO City or To	ON (Street a own, State)	ind Number o	or Rural Rou	te Number,
글 그 이 트	. 1 😑 1	29e. CERTIFIER (Check only one) 1 CERTIFYING PNY 2 MEDICAL EXAMI	SICIAN: To the best of sER: On the basis of s											nd manner sa stated
TO THE HOSPIT TO THE FUNERA De filed within 7	8	296. SIGNATURE AND TITUE OF GENTIL	MM	/ who				29c. LICE 0 4	16	BER O		29d, DATE	SIGNED (M	forgin, Day, Year)
^	2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAU		ITEM 27 (Type		rra	1/	A-III	2 1	T	7117	1 2	133)

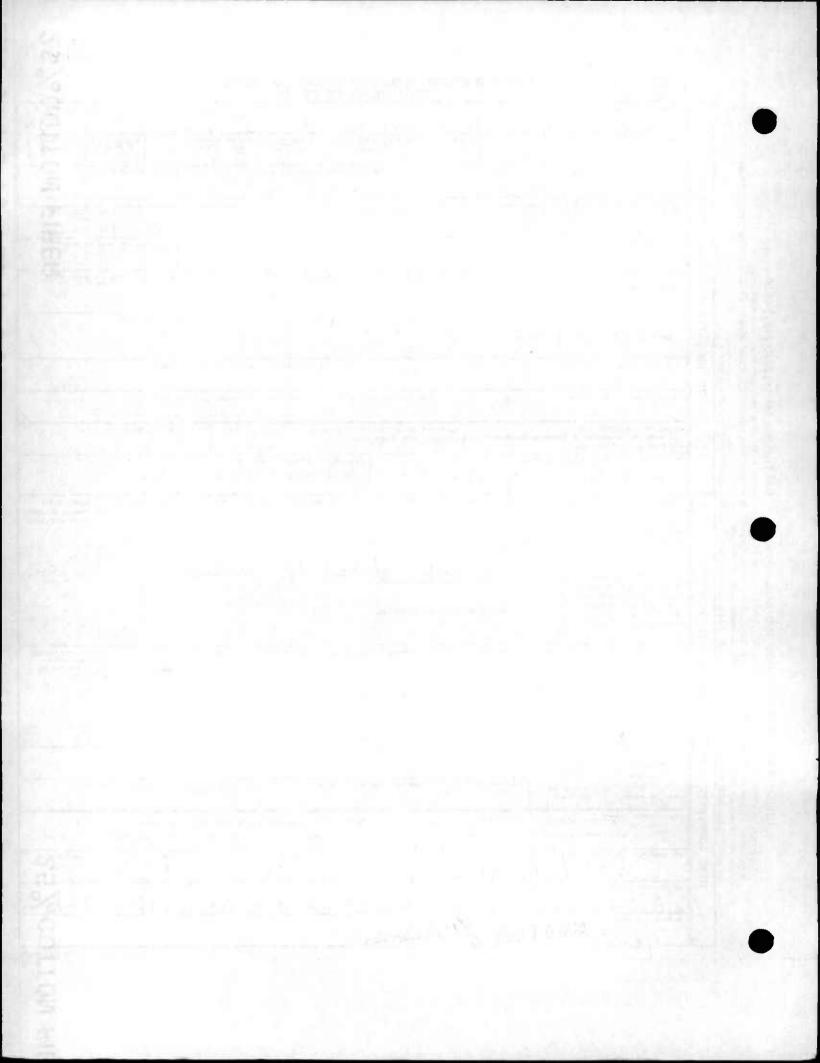
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

DHMH-16 Rev 1/89



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

111 Penn Street, Baltimore, Maryland 21201

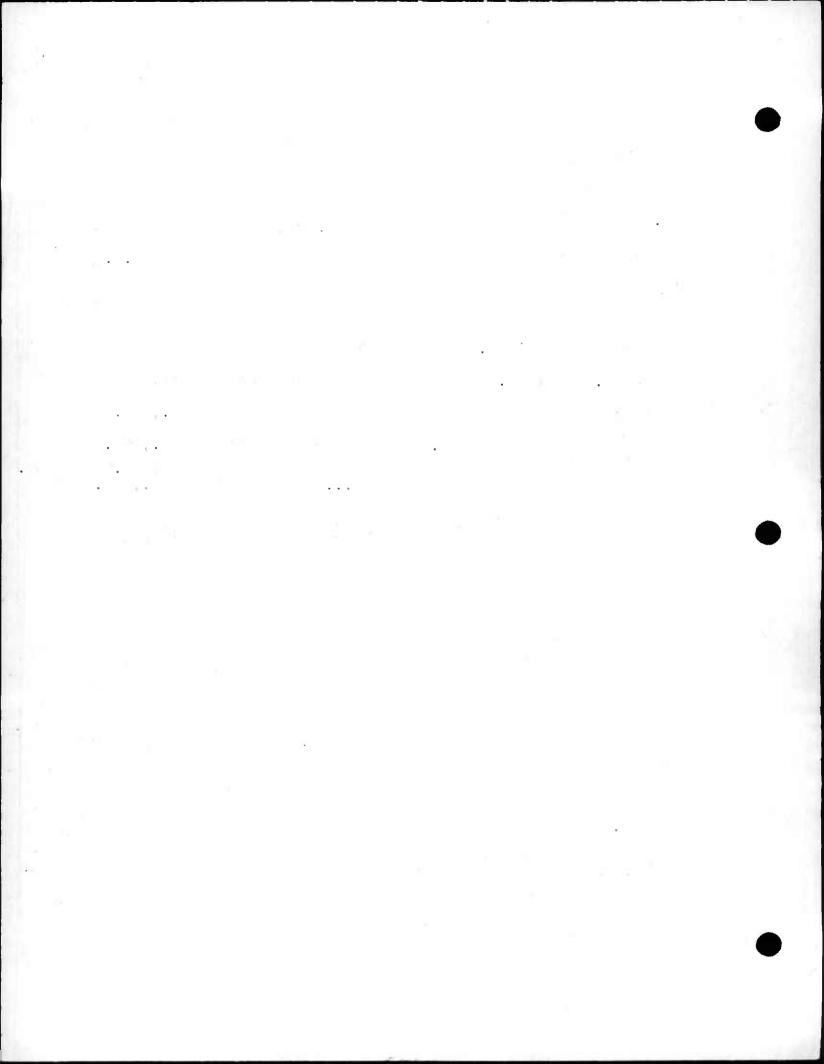
			GEORGE EWELL MONTH DAY YEAR										3. TIME OF DEATH			
	·		4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE (I	In yrs. last	birthday)	IF UNDER	1 YEAR	IF UNDER	24 HBS	JULY 7. DATE OF BIRTH	27 19	27 1995 11:47 8. BIRTHPLACE (State or Fore)	
	P		213-30-33		1 ∰M 2 □ F		58		ONTHS	DAYS	HOURS	MIN.	10-03-3	86	Ma	ryland
	3 should		90. FACILITY NAME (If not it 410 DENIS								I MOI		HTA		OUNTY OF DEATH	
	72	DIRECTOR	RESIDENCE OF DE		REEI				D	АГІ	TMOI	VE.			N/A	
	ages	Ä	MD.	10b. COUNTY N/A 10c. CITY, TOWN OR LOCATION										10d. INSIDE CITY LIMITS?		
	permit. Pages 1,				<u> </u>				Ba	_	imor	_				1-√ YES 2 □ NO
	Si.	ERAL	410 Denis		reet							U.S	WHAT COUNTRY?			
20	ing physician. the burial-transit	FUNER	11. MARITAL STATUS 1. Never Merried 2		12. WAS DECEDEN	IT EVER IN	U.S. ARM	ED)	13. V	WAS DEC	ENDENT C	F HISPAN	IC ORIGIN? (Specify You, Puerto Ricen, etc.)	es or No	14. RACE	E — Americen Indien, k, White, etc.
215-0020	the hospital or attending physician. detached for use as the burial-tran once.	à	3 Widowed 4 Div		IF YES, GIVE Y						2 NO					"y:Black
215	r attend use as	E	15. DEC (Specify on	EDENT'S EDU y highest grade	CATION completed)	T	16a. DEC	EDENT'S U	SUAL OC	CUPATIO	ON st of workin	ng .	16b. KIND OF B	JSINESS/INC	USTRY	
21	d for	COMPLET	Elementary/Secondary ()-12)	College (1-4 or 5			kind of wo				·9	0			
LAND	the hospit detached once.	MO	12th 17. FATHER'S NAME (First, A	liddle (nat)	4yrs.		Soc	ial	WOI	cke:			Social		Vic	es
YL	2 de 19		George W.		1 Sr						ľ		ME (First, Middle, Maide ine Jack			
MARY	5 should in notified	BE C	19a. INFORMANT'S NAME (I DI.		196.	MAILING A	DDRESS	(Street e					Codel	
Z	be ret	5	Patricia	Mitch	e11					DDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) eacon Hill Court Balto., MD. 2					21225	
RE	ector, page		20e. METHOD OF DISPOSIT		20b. PLACE AND DATE OF DISPOSITION / Name of DATE 20c. LOCATION - City of Town State							our State				
M	direct		4 Donation 5 Other (Specify) MT. Zion Cemetery 7/31/95 Balto., MD.										•			
BALTIMORE,	after death. Page 6 may be retained by by the funeral director, page 5 should be moval. Total examiner must be notified at		Olire		/ .	CFSI	PE	281			D ADDRES			21-27	N.I	Monroe St. D. 21217
ш			23. PART I. Enter the d	Isaasas, DI	complications the	R caused	the deal	th. Do no	t entar	tha mo	de of dyl	ng, such	as cerdisc or res	piratory err	est,	Approximate
09	within 24 hour pletely filled lucemation, or end, the me		iMMEDIATE CAUSE (Figure 4 disease or condition resulting in death)	eert fallure.	interval Be							interval Between				
	in certificate be execu- lending physician and il Hygiene prior to bur or other traumatic	CERTIFICATION	Sequentially list condit if eny, leading to imme ceuse. Enter UNDERLY CAUSE (Disease or inju- that initiated events resulting in deeth) LAS	diete ING Iry	C	(OR AS A			: ор:							
DS,	y the att of Menta injury,	. 11	PART II. Other significa	nt condition	s contributing to	deeth bu	It not res	sulting in	the und	derlying	cause g	iven in I			24b.	WERE AUTOPSY FINDINGS
ECORD	signed Signed Health Ws an	IEDICAL	Chor	4°C	Blooke	isn	^_							RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Œ	S 0 66 76	N.	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF	F DEATI	H YES		10 🗆	UNC	ERTAIN				YES 2 NO
VITAL	cortificate has be to the State Dept.	PHYSICIAN	25. WAS CASE REFERRED T EXAMINER?	MEDICAL	HOSPITAL:	2	26. PLACE	OF DEATH	(Check or							
5	ertific the Si	ΙΧSΙ	1X YES 2 □ NO		1 🗆 Inpatient 2 🗆		-	DOA 4	☐ Numl	ng Home		sidence (6 Other (Specify)			
N OF	E # 1	BY PH		Pending Investigation	28e. DATE OF (Month, D	INJURY lay, Year)		28b. TIME (INJUR	OF :	28c. INJU WOI 1 Y	JRY AT RK? ES 2	NO	28d. DEŞCRIBE HOW	INJURY OCC	URED	
DIVISION	TOR: A after d	ETED 8	3 Suicide 8	Could not be determined	28e. PLACE O building,	F INJURY - etc. (Specif	— Al home	e, term, stre	et, tacto	ry, office			281. LOCATION (Street City or Town, State	end Number	or Rural R	oute Number,
0		COMPLE	29e. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the best of	my knowle	odge, desti	h occurred	at the tin	ne, date	end place,	end due 1	to the ceuse(e) end ma	nner ee stat	ed.	
	FUNERAL WITHIN 72 I	8	- Annual Control of the Control of t			xemination	end/or Inv	restigation,	In my op	inlon, de	eth occun	ed at the t	ime, date end place, e	nd due to th	e ceuse(e)) end menner ee stated.
	2 3 3 4 4 5 6 4 4 7 9 9 9 9 9 9 9 9 9 9	O BE	296. WIGHATURE AND TITLE	OF CERTIFIE	- Cock	te !	MD					NSE NUM	M.E.			(Month, Day, Year) 28, 1995
		~ 11					У									

for locke

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

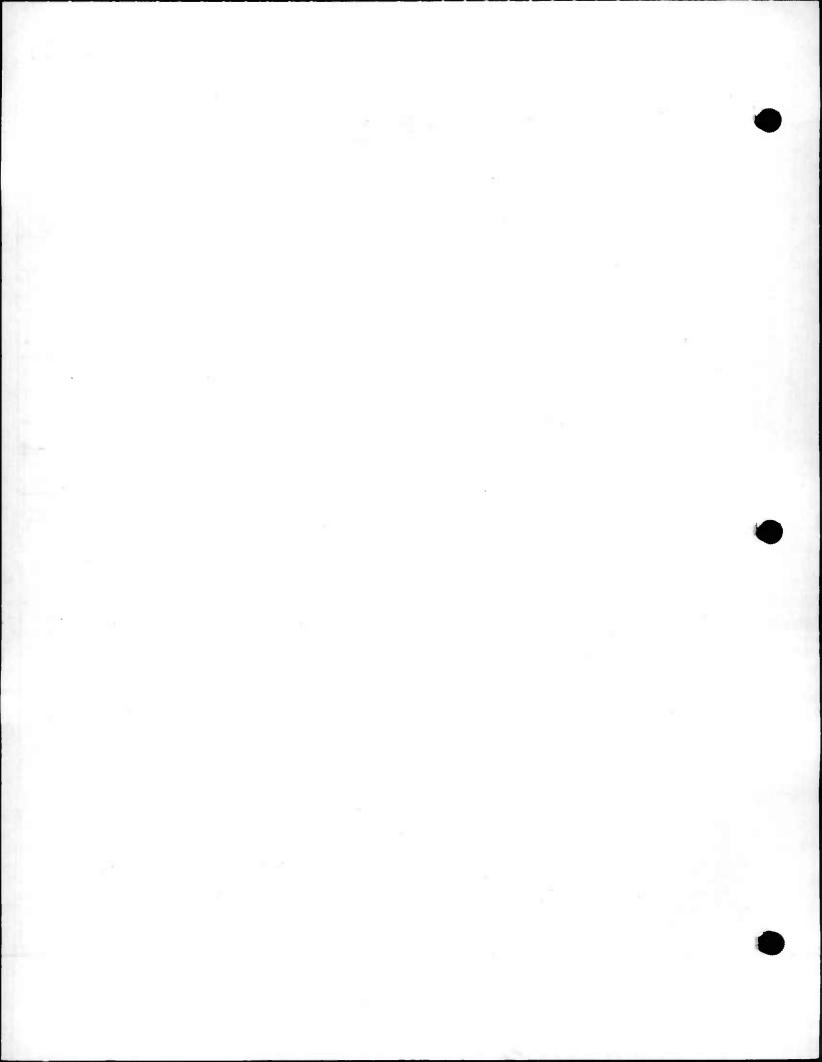
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	CONTAIN OF ATTENDING DUNCHOLMS TO IT AND ALL A
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		1 - FOR STATE REGISTRAR		STATE OF M	IARYLAI	ND / DEPAI	RTMENT OF	HEALTH AND	MENTA	AL HYGIE				
		1. DECEDENT'S NAME (First, I	Middle, Last)	MICHAEL		FAR!	RELL		2. DAT	UI 31	⁰⁴ 995	YEAR	3. TIME OF DEATH 2:25 am	
99		4. SOCIAL SECURITY NUMBER 215-03-1637		5. SEX 1 (X) M 2 () F	6. AGE (In)	yrs. lest birthdey) YRS,	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mor	e 19.	1918	Counti	PLACE (State or Foreign	
2, 3 shoul	OB	99. FACILITY NAME (If not inst Saint Josep	in Medic	et and number) al Center			96. CITY, TOWN	OR LOCATION OF D	EATH	- 1.7.	9c. CQU	NTY OF D	EATN	
- S	딢	RESIDENCE OF DECE	10b. COUNTY	TY 10c. CITY, TOWN OR LOCATION 16d INC.								THE STATE OF THE S		
mit. Pag	L DIRECTOR	Maryland 100. STREET AND NUMBER	Balt	timore Monkton								10d. INSIDE CITY LIMITS? 1 YES 2 NO		
ed.	FUNERAL	Continent on the continent	01	. 1 . D I			1	of. ZIP CODE			10g. CITI		VHAT COUNTRY?	
cian. -trans	=	17530 Wesle		el Road 12. WAS DECEDENT	EVER IN II	0 40450	40 11110 00	21111					5.A.	
ending physician. as the burial-transit permit. Pages 1, 2, 3 should	B	1 Never Married 2 N N 3 Wildowed 4 Divorce	lerried	FORCES? 1	X YES	2 NO	If yes, s	CENDENT OF NISPA Specify Cuben, Mexic S 2 X NO Speci	en, Puerlo	N? (Specify \ Rican, stc.)	fea or No—	Speci	E — American indian, d, While, alc. dy: 11te	
	G	15. DECE	DENT'S EDUCA	(TION	10	Sa. DECEDENT'S	USUAL OCCUPAT	ION	16	b. KIND OF 8	USINESS/IND		irce	
spital or led for u	COMPLET	Elementary/Secondary (0-1		College (1-4 or 5+)		at Cut	work done during in se retired.)	nost of working		Λ 9.	P. Te	2 CO		
the hox detach	Š	17. FATNER'S NAME (First, Mid	dle, Last)		110	ao cao	001	18. MOTNER'S N.	AME (First,			a cc	•	
के वे क	BE 0	James Fa	arrell					Juli	aDon	ohue				
retained 5 should notified	10 8	19s. INFORMANT'S NAME (Typ				19b. MAILING	ADDRESS (Street	and Number or Rural			own, State, Zip	Code)		
	۴	Mrs. Patricia	a Anne	<u>Kalinow</u>	ski	2509	9 Easter	n Ave.	2122	4				
e 6 ma		29a. METHOD OF DISPOSITIO 1 Description 2 Description 3 D	3 🗆 Ramov Specify)	1	cemete	ry cramatory or o	of DISPOSITION (Another place)	Cemetery	8/3/		ocation —			
ral direction		21. SKINATURE OF FUNERAL	SERVICE LICE	SEL	11	C.J.I.C.J	22. NAME A	and J. R	ACILITY		1 11-	. 7	ar y rana	
after death. Pag by the funeral dir moval.		Vomald	" Ves	laps of	K		5305	Harford	Rd.	Balto	o. Md.	212	nc. 14	
		23. PART I. Enter the dis- ahock, or her	eases, or co art fallure. Li	molications that only one caus	caused the	ne death. Do i	not enter tha m	ode of dying, au	ch as cer	diac or res	piratory arr	est,	Approximats Interval Between	
y fille		IMMEDIATE CAUSE (Fine disease or condition resulting in death)		POST O	STRU	CTIVE PI	VEUNOMI	Α					Onset and Daath	
8 5 3				DUE TO (OR AS A CO	ONSEQUENCE O	F):							
be esclan a	RTIFICATION	Sequantially list condition if any, leading to immedicause. Enter UNDERLYIN	ate	DUE TO (OR AS A CO	ONSEQUENCE O	F):							
certificate ding physi lygiene pri	윤	CAUSE (Diseese or injury that initiated eventa	-	DUE TO (DR AS A CO	ONSEQUENCE O	F):							
	토	resulting in death) LAST											İ	
deat att	B	DART II OIL III	0.											
that the ed by the and any Ir	EDICAL	PART II. Other significant	MPRES	contributing to d	T MAI	not resulting N BRON	In the underlyin CHUS	ng cause given in	Part I.		N AUTOPSY ORMED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
w requires the been signed of Health shows an	≥												1 - YES 2 - NO	
law las b Dept.	PHYSICIAN:	DID TOBACCO US		BUTE TO CAL					Ν□					
는 음을 등	힐	25. WAS CASE REFERRED TO EXAMINER?	1	IOSPITAL:			OTHER:)						
PHYSICIAN: The this certificate with the State	14S	1 TYES 2 THO	1	2Sa. DATE OF I	_		4 - Nursing Hor	me 5 🗆 Rasidenca						
this with		1 Netural 5 Pe	ending	(Month, Day		28b. TIM	IURY W	JURY AT ORK?	28d, DE	SCRIBE HOW	INJURY OCC	URED		
After death	ВУ	2 C Sutates	restigation	28s. PLACE OF	INJURY _	Al home form	etreel, factory, offic	YES 2 NO						
TOR: after 28 1	TED		ould not be termined	building, a	tc. (Specify)	re noine, latti,	on eet, rectory, orm		City	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
OR DIRE	3	29a. CERTIFIER	YING PHYSICI	AN: To the heat of a	m knowlede	no double comm	ad at the time at a							
Z 42 =	COMPLETED							e and place, and dur death occured at the					and manner as stated.	
FUNEF Within		29b. SIGNATURE AND TITLE O						29c. LICENSE NU		January 4				
TO THE HOSPI TO THE FUNER be filed within	BE	exegina	N P	mol	to	m 5		D 4141			29d. DATE	SIGNED	(Month, Day, Year)	
665₹	5	30. NAME AND ADDRESS OF F	ERSON WHO	COMPLETED CAUSE	OF DEATH	(ITEM 27) (Type	Print)		1 602 m 1	1145	1 0	1-3)1- 13	



BALTIMORE, MARYLAND 21215-0020 for death. Page 6 may be retained by the hospital or attending physician. The furneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPART	MENT OF H	EALTH AND DEATH	MENTAL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)	HMA	· N	2. DATE OF DEATH DATE OF DATE OF DEATH DATE OF DATE	YEAR 1995	3. TIME OF DEATH				
DIRECTOR		1X M 2 □ F 87	YRS.	IF UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN. R LOCATION OF DI	7. Dare OF BIRTH (Month, Day, Year) April 13	1914 West	t Virginia		
	Bel Air Convalesce	Bel Air Convalescent Center Bel Air Harford								
	100, STATE Maryland 100, STREET AND NUMBER	rdalk				10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	1813 Marshall Road	21 2 2 2		united:	States					
ВУ	11. MARITAL STATUS 1 Never Merried 2 Married 3 X Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify: 1, yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify: 1, yes, specify Cuben, Maxican, Puerto Rican, etc.)						Yea or No 14. RACE — American Indian, Black, White, etc. Specity: White			
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.)								
BE COM	17. FATHER'S NAME (First, Middle, Last) Walter Fleshman					ME (First, Middle, Maiden Zummerman	Sumame)	-		
TO B	100. INFORMANT'S NAME (Type/Print) Louise Sawyers		195, MAILING A	DDRESS (Street a	nd Number or Aural Lane Bel	Route Number, City or Town	Land 210	15		
	20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION - City or Town, State Commeter, crematory or other place) Part 20c. LOCATION - City or Town, State Commeter, Crematory or other place) Part 20c. LOCATION - City or Town, State Commeter, Crematory or other place) Part 20c. LOCATION - City or Town, State Commeter, Crematory or other place) Part 20c. LOCATION - City or Town, State Commeter, Crematory or other place) Part 20c. LOCATION - City or Town, State Commeter, Crematory or other place) Part 20c. LOCATION - City or Town, State Commeter, Crematory or other place) Part 20c. LOCATION - City or Town, State Commeter, Crematory or other place) Part 20c. LOCATION - City or Town, State Commeter, Crematory or other place) Part 20c. LOCATION - City or Town, State Commeter, Crematory or other place) Part 20c. LOCATION - City or Town, State Commeter, Crematory or other place) Part 20c. LOCATION - City or Town, State Commeter, Crematory or other place) Part 20c. LOCATION - City or Town, State Commeter, Commeter									
NO	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, effock, or heart fellure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onest and Death 34 has a consequence of condition reaulting in death)									
CERTIFICATION	Sequentially liet conditione, If any, leeding to Immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated evente resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Organic Brain Syndrome Secretary to Cerebellar Degeneration alcoholism DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: QTHER:									
	27. MANNER OF DEATH 1 Netural 5 Pending	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 28s. DATE OF INJURY (Month, Dsy, Year) 28b. TIME OF INJURY AT WORK? 28d. DE\$CRIBE HOW INJURY OCCURED								
TED BY	2 Accident 3 Suicide 4 Homicide Investigation M 1 YES 2 NO						loute Number,			
COMPLETED	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER 29d. DATE SIGNED D34652 → July					
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SCOTT NASWELL MD 2 NORTH AVE BELAIR MANYLAND 21014 31. DATE FILED (Month, Day, Year) 12. REGISTRAR'S SIGNATURE									
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		1 - FOR STATE OF MARYLAND) / DEPARTMI CERTIFICA	ENT OF H	EALTH AND MEI	NTAL HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last) Friedheir			2.	DATE OF DEATH	19 95	3. TIME OF D	EATH PM
		4. SOCIAL SECURITY NUMBER 2 5. SEX 6. AGE (In yrs. 2 1 5 M 2 1 F 8 8		NDER 1 YEAR 'HS DAYS		DATE OF BIRTH (Morth, Day, Year)	6. BIRTHI Country	PLACE (State of	r Foreign
2, 3 should	OR	9a. FACILITY NAME (If not institution, give street and number) SINAT HOSPITAL	9b.	96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE 9c. COUNTY OF DEATH N/A					34
Pages 1,	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c. CITY, TOY	WN OR LOCAT	ION			10d. INSIDE C	YTK
permit.	A	MARYT, AND N/A 10e. STREET AND NUMBER 7 COBBLESTONE CT, APT. 2-B			TIMORE ZIP CODE 2121	5 10	9. CITIZEN OF W	1 X YES 2	
020 physician. burial-transit	FUNER	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. 1 Yes 2 FORCES? 1 YES 2	ARMED	13. WAS DECI	ENDENT OF HISPANIC O	RIGIN? (Specify Yes or I	No- 14. RACE Black	— American II	ndlan,
5-0 ending as the	D BY	3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES		1 🗌 YES	2 XNO Specify:		Specifi		re
21 for u	PLETE	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12	(Give kind of work diffe. Do NOT use retin	one during mos ed.)		16b. KIND OF BUSINE	SS/INDUSTRY) DICTO	OT DI WITC
MARYLAND : retained by the hospital 5 should be detached it notified at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	MANAGER		18. MOTHER'S NAME (First, Middle, Maiden Surn		DIST	(IBOIO
2 × 2 ×	1	LEO FRIEDI			RACHA			STACK	
E, MAR) y be retained to sage 5 should be notified	5				ROAD REIST				
ALTIMORE, death. Page 6 may be tuneral director, page xaminer must be		1 ABbrisi 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	CEAND DATE OF DIS		ESED - 7-3	1-1995 RAN	ON — City or Tow VDALLSTO	WN, MI)
0 = 0		21. SIGNATURE OF FORERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215							21215
of within 24 hours after ompletely filled in by the II. cremation, or removal event, the medical		23. PART i. Enter the disesses, or complications that caused the ahock, or heart feliure. Liet only one cause on each ii iMMEDIATE CAUSE (Finel disease or condition resulting in death) Ten Sign.	ine.				ry arrest,		imsta i Between and Death
P.O. BOX 687, th certificate be executed ending physician and con I Hygiene prior to buniat, or other traumatic er	CERTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Tension DUE TO (OR AS A CONSTITUTE OF TO (OR AS A CON		[ns	ufficie	ncy		Zu	reeks
L RECORD; aw requires that the s been signed by the ppt. of Health and M 3 shows any Inji	MEDI	PART II. Other significant conditions contributing to deeth but no rup ured abdo mina and r	ric ane	ury:	sm, acul	PERFORMED	n 6	WERE AUTOPSY MAILABLE PRIC COMPLETION O OF DEATH?	OR TO OF CAUSE
	PHYSICIAN:	EXAMINER? HOSPITAL:		IER:					
OF VIT, PHYSICIAN: The this certificate with the State ted, or Item	энх	27. MANNER OF DEATH 28. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	Nursing Home 28c, INJU WOF	5 Residence 6 D	Other (Specify) DESCRIBE HOW INJUR	TY OCCURED		
IDING PHYS After this of death with	ВУ	2 Accident Investigation	١.	1 Y	ES 2 NO	_			
DIVISION OF VITA OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate h hours after death with the State E item 28 is marked, or item	ETED	3 Suicide 6 Could not be 4 Homicide 6 Could not be determined	nome, farm, atreet,	factory, office	261.	LOCATION (Street and N City or Town, State)	lumber or Rural Ro	ute Number,	
Z ZZ Z	COMPL	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, one) 2 MEDICAL EXAMINER: On the best of exemination end/						and manner as	s stated.
TO THE HOSPI TO THE FUNEF be filed within	TO BE (296. SIGNATURE AND TITUE OF DESTIFIER. SUITGETY	Resid	ent	29c. LICENSE NUMBER	7KF/1595	July 2	Month, Day, Yes	75
/		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (I	TEM 27) (Type, Print) La Ke I	tven	Ne Ba	Himore	MD	212	212
9		31. DATE FILED (Month, Dex. Year) ALIC A 1 1995							

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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be filled within 72 hours after death with the State Dept. of Health and Merital Hyglene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FilmG, 726, it		-				MENTAL HYGIEI		5	23050
	1 - STATE REGISTRAR	OIAIL OI III				F DEATH	REG. NO	_		
	1. DECEDENT'S NAME (First, Middle, Last) MAZIF	MAZIE V V CAS	IRGINIA TICER	GAS.	PIGER				YEAR 995	. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. les	t birthday)	IF UNDER 1 YEA		7. DATE OF BIRTH (Month, Day, Year)	1	BIRTHPL Country)	ACE (State or Foreign
~	212-30-0495 9a. FACILITY NAME (If not institution, give s	street and number)	12		9b. CITY, TOW	VN OR LOCATION OF I	03-02-192 DEATH	9c. COUNT	ARYI Y OF DEA	
DIRECTOR	927 CATAWBA COUR				LAN:	SDOWNE		BAL	TIMO	RE
DIRE	MARYLAND BALTI				, town on lo INSDOWN					Dd. INSIDE CITY LIMITS? YES 2 X NO
FUNERAL	10e. STREET AND NUMBER					101. ZIP CODE			N OF WH	AT COUNTRY?
FUN	927 CATAWBA COUR 11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT FORCES? 1	YES 2 X	MED	13. WAS I	21227 DECENDENT OF HISP/ , specify Cuben, Maxic	ANIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)	U.S.	4. RACE -	American Indian, Vhite, atc.
ED BY	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WA	n 2000-0			YES 2 X NO Spec	ify:		Specify:	WHITE
	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(GI	CEDENT'S I ve kind of w Do NOT use	USUAL OCCUP. rork done during a retired.)	ATION most of working	18b. KIND OF BU	JSINESS/INDU:	STRY	
COMPL	7 17. FATHER'S NAME (First, Middle, Last)	0	H	OMEMA	KER	18. MOTHER'S N	OWN H			
BE C	MILTON WATTS 19a. INFORMANT'S NAME (Type/Print)		100			ALICE	KNOTT			
5	ROSE M. KELLY						Route Number, City or Too SDOWNE, MAR			7
	20s. METHOD OF DISPOSITION 1X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) GLEN HAVEN MEMORIAL PARK 8/2 GLEN BURNIE, MD									
	22 NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME								, FID	
Н	22. PART . Enter the diseases, or	emplications that	coused the de	ath Do n	1 SE	COND AVE.	S.W. GLE	N BURN	NIE,	
	IMMEDIATE CAUSE (Finel	List only one caus	e on each line.		or enter the	mode of dyring, au	cii aa cerdiac or reap	oratory arres	ы,	Approximata interval Betwee Oneet and Deat
	disease or condition resulting in death)	DUE TO (OR AS A CONSEQUENCE OF):							Two OI	
CATION	Sequentially liet conditione, if any, leading to immediate cause. Enter UNDERLYING								2041	
ERTIFICA										
CER	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDING									
EDICAL	PART II. Other significant condition	a contributing to d	leath but not re	neulting in	n the underly	ying cause given in	Part I. 24a. WAS AF PERFO	RMED?	CC	ERE AUTOPSY FINDING: AILABLE PRIOR TO DMPLETION OF CAUSE DEATH?
Σ	1 O YES 2 NO									
ICIAN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
PHYSICIAN:	1 PES 2 DATE OF INJURY 28h TIME OF 28c INJURY 28h TIME OF 28c INJURY AT 28d DESCRIPE HOW INJURY OCCUPED									
BY	2 Accident Investigation	Netturel 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO								Alumba.
ETED	4 Homicide determined	building, at	tc. (Specify)				City or Town, State		noral ricol	- Number,
OMPLET							e to the cause(s) end me			nd manner as stated
BE CO	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, dasth occursd at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CONTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)									
29b. SIGNATURE AND TITLE OF CENTIFIER 29b. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DA 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20 (Top Bright))								17,	13	V95

DIAMERO

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

OHOL SITO SIS CONTO

31. DATE FILED (Month, Day, Year)

AUG 0 1 1995

Julia dawler Radall

31. DATE FILED (Month, Dey, Year)
AUG 0 1 1995

FOR STATE REGISTRAR

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH CAROLYN GAITHER JÜLY 26, 1995 1:40P 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 218-36-1065 1 M 2 V F 52 09/24/42 MARYL AND completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should rial, cremation, or removal. Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR JOHNS HOPKINS HOSPITAL BALTIMORE CITY BALTIMORE 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE BALTIMORE TY YES 2 NO 10e, STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2920 RAYSHIRE ROAD 21230 ILS A 24 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 X NO Specify: 1 Never Married 2 Married Specify: BLACK BY 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done ife. Do NOT use retired.) most of working Domestic ntary/Secondary (0-12) College (1-4 or 5+) - DOMESTIC HOME MAKER notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) BENJAMIN FLEET JR. BE MARION A.FLEET 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ANITA GAITHER 2920 RAYSHIRE ROAD BALTIMORE, MARYLAND 21230 9 20p. METHOD OF DISPOSITION
1AD Burlai 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must CARBUTUS OF MEM. PARK & 7/31/95 ARBUTUS, MARYLAND medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE BROTHERS FUNERAL HOME 0 1300 EUTAW PLACE BALTIMORE, MARYLAND 21217 23. PART I. Enter the discess, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each lips. Approximate interval Between IMMEDIATE CAUSE (Final Onset and Deeth the disesse or condition SEPSIS 36 hrs executed within reaulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): burial, LEAKING CECOSTOMY other traumatic CERTIFICATION this certificate has been signed by the attending physician and with the State Dept, of Health and Mental Hygiene prior to buri Sequentielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF if sny, leading to immediate cause. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be STEROIDS STEMIC CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST Lapus ERYTHAMATOUS PART ii. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 - YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK?
1 YES 2 NO 28a. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked, Natural 2 Accident 5 Pending Investigation DIRECTOR: After the hours after death ΒY after de 28 Is 3 Sulcide 28s. PLACE OF INJURY — At home, farm, atreet, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE DE filed within 72 hours at IMPORTANT: It item 21 29a, CERTIFIER 1 K CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 296. MIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) SHREICHT RESIDENT 043527 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BALTIMORE, HOPKINS HOSPITAL, JOHNS ANKESH 31. DATE FILED (Month, Day, Year)
AUG 01 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

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31. DATE FILED (Month, Day,

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32. REGISTRAR'S SIGNATURE

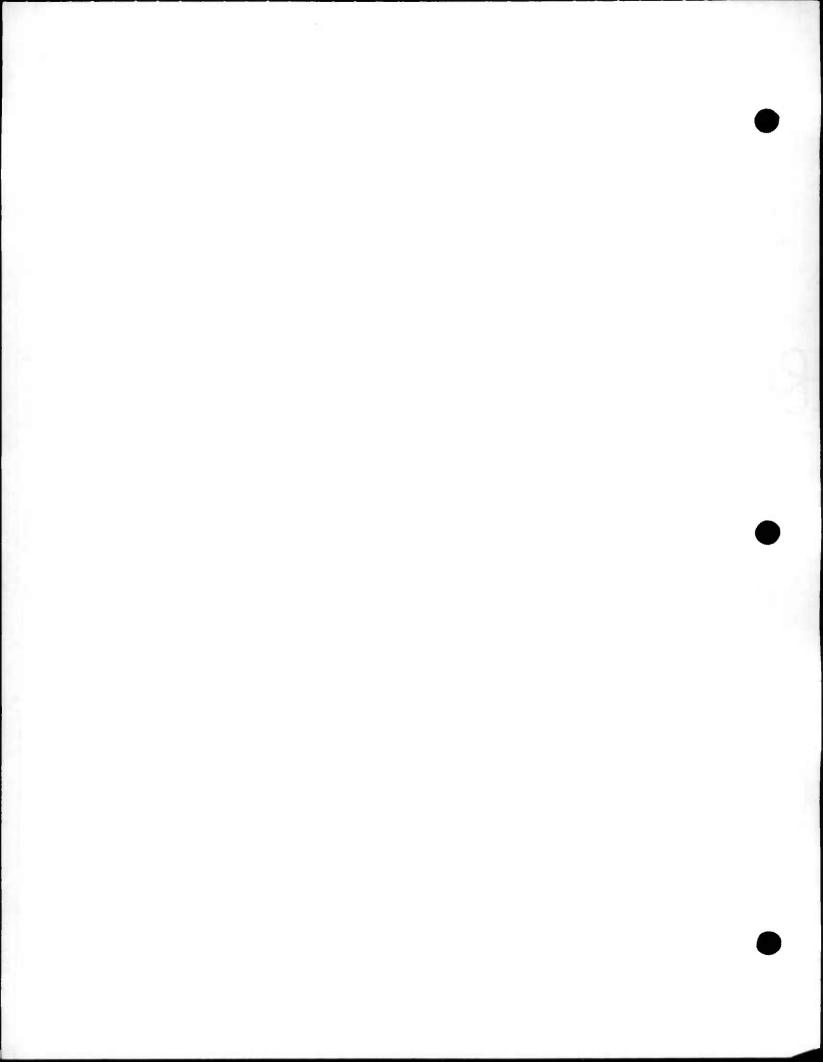
funeral director, page 5 should be detached for use as the burial transit filled in by the fi cremation, completely burial, and Hygiene prior to HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be certificate has been signed by in the State Dept. of Health and this c After t DIRECTOR: / TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTL be filed within 72 hours at IMPORTANT: If item 2!

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH MARJORIE LAURA GUTFLEISCH MARJORIE GUTTELLC Y.TIIL 1995 15:43 4. SOCIAL SECURITY NUMBER S. SEX 8. AGE (In yrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 7 DATE OF BIRTH MAY 12, 1906 FREDERICK, MD. 215-30-2415 1 🗌 M 2 💟 F 89 9a. FACILITY NAME (If not institution, give etreet end number 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR BALTIMORE CITY 3716 E NORTHERN PKWY BALTIMORE 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE CITY BALTIMORE 1 YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3716 E. NORTHERN PKWY. 21206 USA 12. WAS DECEDENT EVER IN U.S. WIRMED FORCES? 1 YES 2 YNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—It yes, specify Cuben, Maxican, Puerto Rican, etc.)
 T YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried BY 3XXWidowed 4 Divorced WHITE 16a. DECEDENT'S USUAL OCCUPATION LETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work life. Do NOT use re tary/Secondary (0-12) TELEPHONE OPERATOR U.S. GOVERNMENT COMP 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)
MARGETT RICE MARION C. MILLER BE 19a, INFORMANT'S NAME (Type/Print) 96. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3716 E. NORTHERN PKWY. BALTIMORE, MARYLAND 21206 2 FRITZ A. GUTFLEISCH 20a. METHOD OF DISPOSITION
1.\(\text{L}\) Burlel 2 \(\text{Cremation}\) Cremation 3 \(\text{L}\) Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE MORECAND MEMORIAL PARK JULY 28, 1995 BALTIMORE, MD. ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE, OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY LASSAHN FUNERAL HOME 7401 BELAIR ROAD BALTIMORE, MD. 21236-4625 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reaplratory arrest, shock, or heert failure. List only one cause on each line interval Retween IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) a. Arteriosclerotic Cardiovascular Disease
OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events OUE TO (OR AS A CONSEQUENCE OF): reauiting in death) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Diabetes Mellitus 1 YES 2X NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER: 1 X YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 - Nursing Home 5 N Residence 8 - Other (Specify) 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED Natural ВҰ 1 YES 2 NO Accident Investigation 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be determined 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. 2X MEDICAL EXAMINER: On the basis of exam on end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day, Year) OCME JULY 26,1995 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

DHMH-16 Rev 1/89

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF HEALTH AN	ID MENTAL	HYGIENE REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Lest) DANIEL EDA	AR HAR	RIS SI	R	MONTE	OF DEATH	YEAR 5: 23 PM	
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE ((In yrs. last birthday)	F UNDER 1 YEAR IF UNDER 24 H	48446		BIRTHPLACE (State or Foreign Country)	
should		217-09-2/00 9a. FACILITY NAME (If not institution, give str		S YRS.	b. CITY, TOWN OR LOCATION D	09	30 11	MARYLAND	
2, 3 sh	OR	BAY VIEW	HOSP IT A		BALTIMO		9c, COUNT	Y OF DEATH	
Pages 1,	RECTO	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	1	10c. CITY,	TOWN OR LOCATION			10d. INSIDE CITY	
permit. Pa	Ճ	M D)	1/A	BA	LTIMORL	2		1 NYES 2 NO	
1St	ERAL		TER AVE	ENVE	101. ZIP CODE	24		EN OF WHAT COUNTRY?	
020 physician. burial-transit	J. N.	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	N U.S. ARMED	13. WAS DECENDENT OF HI If yes, specify Cuban, Mr			4. RACE — American Indian, Black, White, atc.	
nding ts the	ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 TYES 2 NO S	pecify:		Specify: WHITCH	
	ETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ompleted)	16a. DECEDENT'S US (Give kind of work life. Do NOT use r	done during most of working		KIND OF BUSINESS/INDUS	STRY	
the hospital or detached for u	COMPL	UNIKNOWN	College (1-4 or 5+)	TRUCI	DRIVER		LOCAL	557	
by the the bedeta	8	17. FATHER'S NAME (First, Middle, Last)	HARRIS			S NAME (First, N	fiddle, Maiden Surname)		
MAR retained t 5 should notified	TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street and Number or R			ode)	
e age be	۴	JAMES E HA. 200. METHOD OF DISPOSITION		3808				0.21224	
I IMORI . Page 6 mar ral director, p		1° Burial 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val from State cam	PLACE AND DATE OF I	place) OF FAITH	7-249	20c. LOCATION — CH	ty or Town, State	
AL I IN death. Pag funeral dis f. examiner		21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE		22. NAME AND ADDRESS O	F FACILITY S. 2.4	ILLEN +SO	N INC	
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3 2 . 91		23. PART I. Enter the diseases, or or ahock, or heart failure. L IMMEDIATE CAUSE (Final	implications that caused ist only one ceuse on e	f the daeth. Do not ach line.	anter tha mode of dying,	auch aa card	lec or respiratory arres	Interval Between	
E 5 2		disease or condition resulting in death)	PULMUN DUE TO (OR AS A	ARY E	DEMA			Onset and Death	
ecuted withing of completely burial, cremat						1./		12	
UX 68/10 be be executed sician and con rior to burial, traumatic or	CATION	y rouding to mimodiate	DUE TO (OR AS A	CONSEQUENCE OF):	DIOMYUPATT	7		1712	
ificate the physic see price	FICA	ceuse. Enter UNDERLYING CAUSE (Disesse or injury that initiated events	DUE TO (OR AS A	CONSEGUENCE OF):					
death certificate attending physical ental Hygiene pri	ERTIFI	resulting in death) LAST						İ	
그 음 등 등 글	AL C	PART ii. Other aignificant conditions				in Part i.	24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS	
law requires that as been signed by lept. of Health an 23 shows any	MEDIC	CHRONIL OBSTR	ICTIVE LUN	6 DISEAS	E		1 TYES 2 TO	AVAILABLE PRIDE TO COMPLETION OF CAUSE DF DEATH?	
AL RECOR	. M	DID TOBACCO USE CONTR	BUTE TO CAUSE O	F DEATH YES	NO UNCERT	AIN 🗆		1 TES 2 NO	
B ich h	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH					
SICIAN: The certificate in the State	PHYS		26a, DATE OF INJURY		☐ Nursing Home 5 ☐ Resider		(Specify) CRIBE HOW INJURY OCCUI	DED.	
After this death with	ВУ Р	17 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	WORK? M 1 YES 2 NO		3.1.52 1.011 1.100111 00001		
TTENDI TOR: A after d	ETED I	3 Suicide 6 Could not be detarmined	26a. PLACE OF INJURY building, atc. (Spec	26a. PLACE OF INJURY — At home, farm, street, factory, offica building, stc. (Specify)			26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
S S S S S S S S S S S S S S S S S S S	PLE	29a. CERTIFIER (Check only	AN: To the beat of my knowl	ledge, death occurred a	t the time, data and place, and	dua to the caus	se(s) and manner sa stated.		
TO THE HOSPITAL. TO THE FUNERAL (De filed within 72 h IMPORTANT: If i	COMPL				n my opinion, death occured at				
THE H filed w	BE	296. SIGNATURE AND TITLE OF CERTIFIER	MO		29c. LICENSE			HIGNED (Month, Day, Year)	
₽₽3 🛎	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OE					131/45	
2		VAHAEN SHATIA		two Hopkin	US BAYUEN	MED	ICAL CENT	ER	
)		31. DATE FILED (Month, Day, Year) AUG 0 1 199	32. REGETRAR'S SIGN	lear Ranfall					



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funeral director, page 5 should be detached for use as the bunial-transit permit.

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after d	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the he filled within 72 hours after years, with the State Daor of Health and Mental Hicipine infort to build incompation or served.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical e

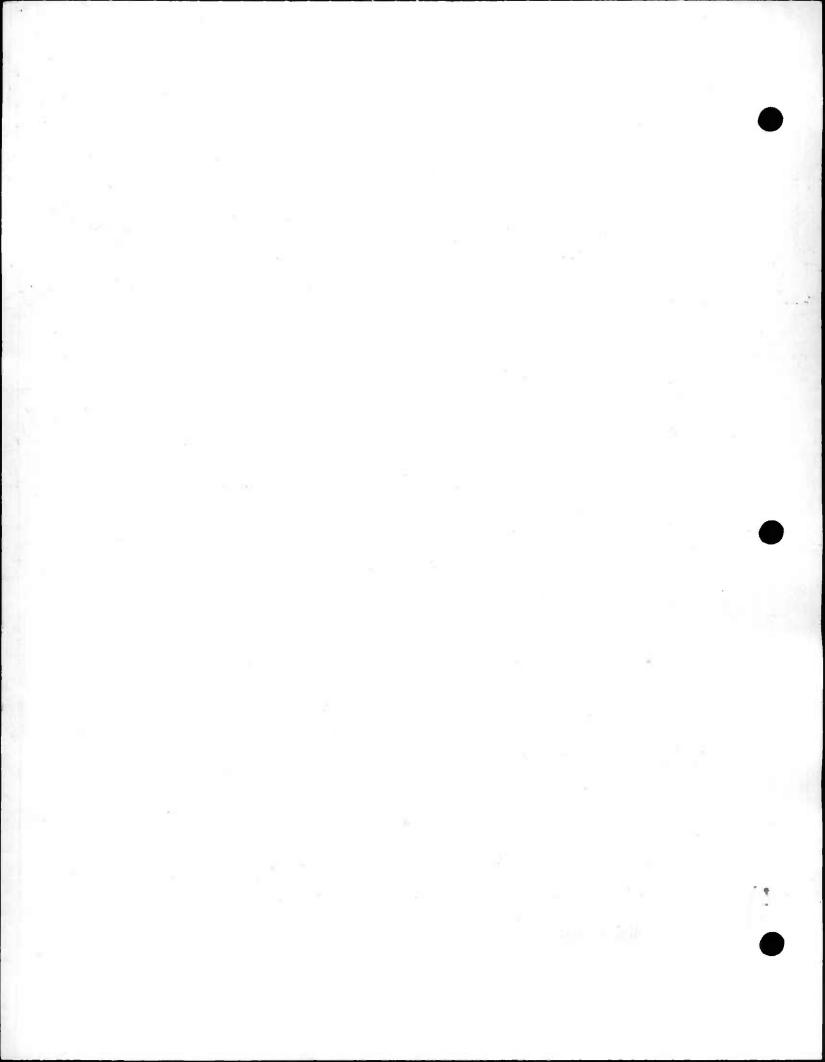
31. DATE FILED (Month, Day, Year)

AUG 0 1 1995

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Arletta Harding 40 A July HARVEY 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year, 6. AGE (In yrs. lest birthday 8. BIRTHPLACE (State or Foreign 74-854 3 1 - M 2 X F 10 June OWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR 10 renera to RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 0 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF 10f. ZIP CODE ve. 500 WAS DECEDENT EVER IN U.S. ARME FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE Black If yes, specify Cube 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES Black BY 3 Widowed 4 Divorced Specify: 18a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION ecify only highest grade complete 16b. KINO OF BUSINESS/INDUSTRY ndary (0-12) (1-4 or 5 +) 2 0 Vaintenance mot THEATHER'S NAME (First, Middle, D ts. MQTHER'S NAME (First, Middle, arrett notified at BE 7 NFORMANT'S NAME (Type/Print) 2 6 pe METHOD OF DISPOSITION must Buriel 2 Cremation Donation 5 Other (Specify) medical examiner SE OF FUNERAL SERVICE LICENSEE E AND ADDRESS GE FACILITY Ave 23. PART I. Enter the disease, or complications that issued the deeth. Do not enter the mode of dying, such as cerdiec or respiratory strest, shock, or heart affure. List only one ceuse on each line. Approximate interval Between IMMEDIATE CAUSE (Finel Onset and Death other traumatic event, the diseese or condition Infective Endocarditis, Septic Emboli resulting in death) OUE TO (OR AS A CONSEQUENCE OF): Cardio-pulmonary Arrest CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate ceuse. Enter UNDERLYING Severe Metabotic Acidosis CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 6 23 shows any injury, PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 💆 UNCERTAIN 🗆 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one HOSPITAL: OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28 is marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO В 2 Accident Investigation 3 Suicide 28s. PLACE OF INJURY — At home, ferm, streat, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide If item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. On the besis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNEO (Month, Day, Year) Waserul Horas 7-29.95

30. NAME AND ADDRESS OF PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Typo, Print)

Syed Haque M.D, C/O Maryland General Hospital



BALTIMORE, MARYLAND 21215-0020

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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the	CTOR: After this certificate has been signed by the attending physician and completely filled in by the	4
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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH DAY 1. DECEOENT'S NAME (First, Middle, Last) 3. TIME OF DEATH **MADELYN** В. HANNAWAY 07-26-95 6:30 P. 4. SOCIAL SECURITY NUMBER IF UNDER 24 HRS. 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 02-25-14 002-32-3897 1 MXXX F 81 NEW HAMPSHIRE 9a. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH **KESWICK** HOME BALTIMORE CITY N/A RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/A BALTIMORE CITY XX YES 2 NO 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 700 WEST 40th. STREET 21211 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 24 AND WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Maxican, Puarto Rican, atc.)
 \(\subseteq \text{YEX X NO} \)
 Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES Specify. 3XXWidowed 4 Divorced WHITE 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16s. DECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INOUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) SOCIAL WORKER YEARS **EDUCATION** 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) PATRICK BRODERICK S. MARY CONNOR 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code **JOHN** HANNAWAY 406 HOPKINS ROAD, BALTIMORE, MD. 21212 METHOD OF DISPOSITION 20e. METHOD OF DISPUSITION

Ltd. Burlet 2 □ Cremeflon 3 □ Removal from State 20b. PLACE ANO DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State ST. JOSEPH CEMETERY 4 Donation 5 Other (Specify) 7-31 BEDFORD, NEW HAMPSHIRE 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
HENRY W. JENKINS AND SONS 4905 YORK ROAD, BALTIMORE, MD. 21212 23. PART I. Entar the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. Approximate Interval Between **IMMEDIATE CAUSE (Final Onset and Death** disease or condition_ isease Theimer resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to deeth but not recuiting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XIX YES 2 | NO AT HOPKIN 1 TYES X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X HEAD ONLY 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:

XI Anursing Home 5 - Residence 8 - Other (Specify) 1 YES XXNO 1 Inpetient 2 ER/Outpetient 3 DOA 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. OEȘCRIBE HOW INJURY OCCUREO XXNatural 1 YES 2 NO Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be 4 Homicide 29a. CERTIFIERX CERTIFVING PHYSICIAN: To fhe best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On basis of examination end/or investigation, in my opinion, death occured at the fime, data and place, and due to the cause(s) end manner ea stated. 296, SIGNATUR 29c. LICENSE NUMBER 29d. OATE SIGNEO (Month, Day, Year) auto: D 34988 07 - 26 - 95

G. ROBERTS, M.D., 6565 NORTH CHARLES ST., TOWSON, MARYLAND, 21204 31. DATE FILEO (Month, Day, Year) AUG 0 1 1995

WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

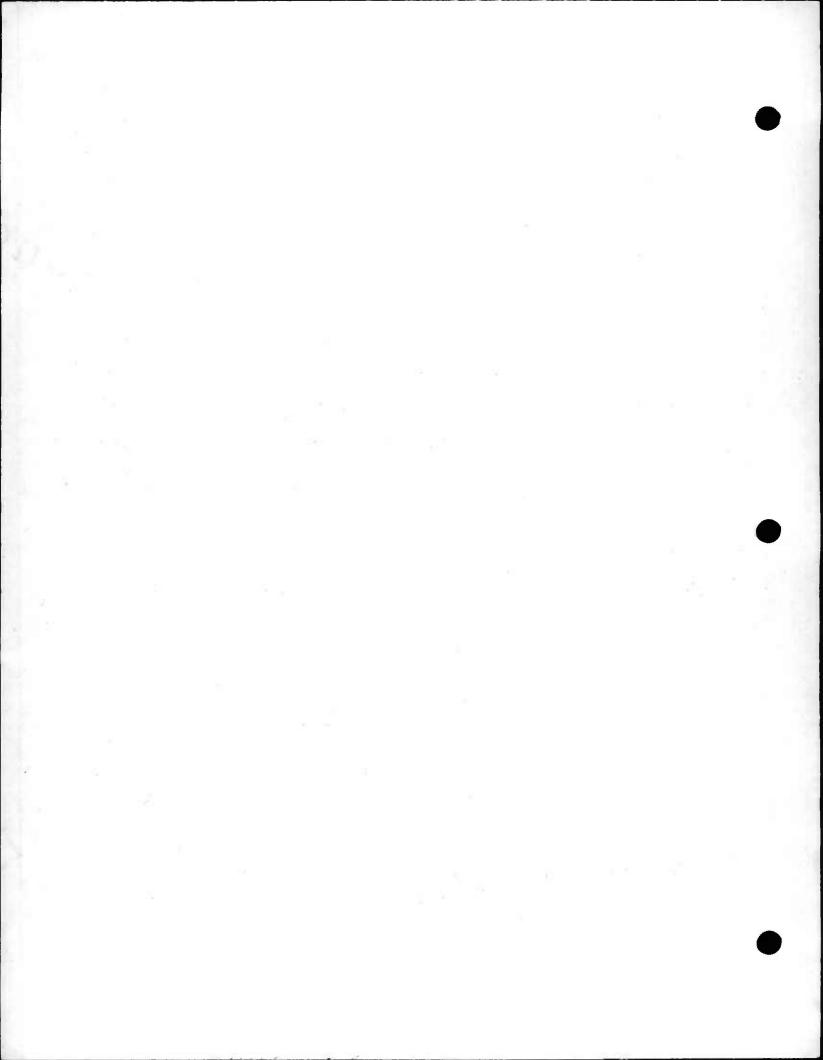
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

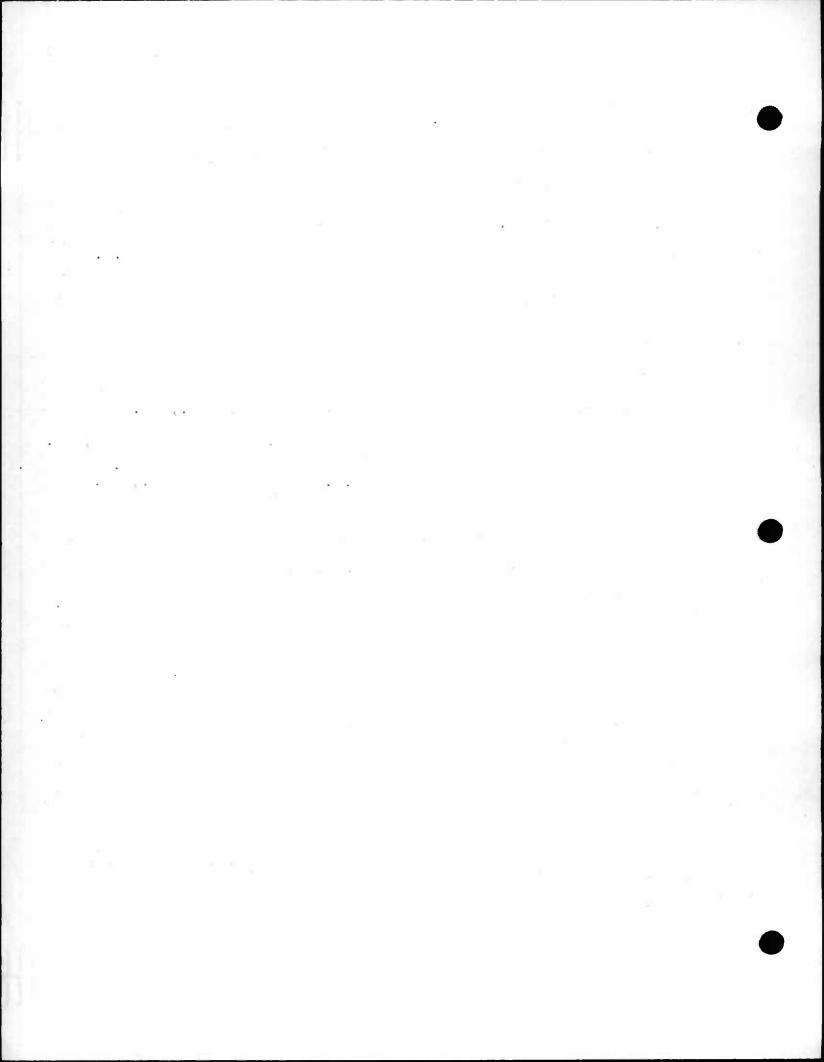
RICHARD	Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATH
	J.	HANLEY							JULY 2		1995 09:13 PM	
4. SOCIAL SECURITY NUMBER	ER	5. SEX	6. AGE (In yrs. In		IF UNDER 1		IF UNDER 24 H		7. DATE OF BIRTH 8. BIRTHPLACE (State or			
217-60-4166	_ =	1 M 2 D F	40	YRS.	MONTHS	DAYS H	IOURS M	NN.	(Month, Day, Year) 10-24-19	54	Counti	w arvland
9e. FACILITY NAME (If not in					9b. CITY, 1	TOWN OR I	LOCATION (OF DEA			NTY OF D	
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	33500-000				TOWN OR		N					10d. INSIDE CITY LIMITS?
Maryland	ватт	imore		Р	hoen							1 TES 2XX NO
13542	T > 20 20 20	ettsville	n 70 d 1				IP CODE			1.5		VHAT COUNTRY?
11. MARITAL STATUS	Jarre	12. WAS DECEDEN			T 45 W		1131				U.S	
1 Never Merried 2	Married	FORCES? 1	YES 2	NO	It:	yes, specif	fy Cuban, M	laxican,	C ORIGIN? (Specify Yea , Puarlo Rican, etc.)	or No-	14. RACE Blaci	— American Indian, c, White, atc.
3 Widowed 4 Divo		IF YES, GIVE V	MAR OR DATES		1 1 (YES 2	NO S	Specify:			Speci	White
15. DEC	EDENT'S EDUC	CATION	16a. DI	CEDENT'S L	JSUAL OCC	CUPATION			16b. KIND OF BUS	INESS/INC	DUSTRY	
Elementary/Secondary (0	highest grade	College (1-4 or 5	100	ilve kind of wo . Do NOT use	ork done du retired.)	ring most o	of working					
		4	0	wner	gO &	perat	tor		Beaver	Dam S	Swim	Club
17. FATHER'S NAME (First, Mi						18			E (First, Middle, Maiden	Surname)		
Mark	P	. Han	nley, Sr	•]	Ell	en McHa	le		
19a. INFORMANT'S NAME (7)			19					Rural Ro	oute Number, City or Town	, State, Zip	Code)	
Eva M. Hanl	2			S	ame A	As #1	10					
20a. METHOD OF DISPOSITI X ☑ Burial 2 ☐ Crematio	n 3 🗌 Remo	oval from State	20b. PLACE	AND DATE OF	F DISPOSIT	ION (Name	of			CATION —	City or To	wn, Stata
4 Donation 8 Dother	(Specify)		Cemetery, cre Mt.	Maria	_			31-		son,	Mary	yland 21204
21. SIGNATURE OF FUNERAL	_		100				ADDRESS O					
Wallace S. Brooke A. Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204												
23. PART i. Entar tha di	seeses, or c	omplications the	t caused the de	eath. Do no	ot anter th	ha mode	of dving.	auch	as cardiac or respi	atory an	reat.	Approximata
ahock, or he iMMEDIATE CAUSE (Fin	art fellure. L	lat only one cau	ise on each line).						,		interval Batween Onset and Death
disease or condition		ARTERIOS	CLEROTIC	CARDIO	VASCUL	AR D	ISEASE	-				Oliset and Daath
resulting in death)												
OUE TO (OR AS A CONSEQUENCE OF):												
Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):												
Sequentially list condition if eny, leading to immediate		DUE TO										
if eny, leading to immed ceuse. Entar UNDERLY!!	liate NG	DUE TO										
if eny, leading to immed ceuse. Enter UNDERLY!! CAUSE (Disease or Injus- that initiated events	diate NG Ty		(OR AS A CONSE	DUENCE OF)	:			_				
if eny, leading to immed ceuse. Enter UNDERLYII CAUSE (Disease or Injur	diate NG Ty			DUENCE OF)	:							
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if eny, leading to immed ceuse. Enter UNDERLY!! CAUSE (Disease or Injus- that initiated events	Mate NG ry	DUE TO	(OR AS A CONSE			arlying ca	ause giver	n In P	PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMMITTION OF CAUSE
if eny, leading to immed ceuse. Enter UNDERLYII CAUSE (Disease or Injui that initiated events resulting in death) LAST	Mate NG ry	DUE TO	(OR AS A CONSE			arlying ca	ause give	n In P		MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
if eny, leading to immed ceuse. Enter UNDERLYII CAUSE (Disease or injust that initiated events resulting in death) LAST	finte NG or or or or or or or or or or or or or	OUE TO	(OR AS A CONSE	aaulting in	the unda				PERFOR	MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE
if eny, leading to immed ceuse. Enter UNDERLYII CAUSE (Disease or Injui that initiated events resulting in death) LAST	district on ditions	OUE TO	death but not i	aaulting in	the unda	0 🗆 1			PERFOR	MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within—25 hours after death. Progression or attending physician. TO THE FUNEAL DIRECTOR: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF M) / DEPAR					MENT	AL HYGIEN	_		
	1. DECEDENT'S NAME (First, Middle, Last)		ph L.	Harı	rod				J ₁	e of death th	AY	YEAR 95	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 231-12-4273 90. FACILITY NAME (If not institution, give str	17€ M 2 🗆 F	6. AGE (In yrs. 77	YRS.	MONTHS	DAYS	IF UNDER	MIN.	(Moi	E OF BIRTH ofth, Day, Year)	1	Vir	ginia
STOR	Inns Of Evergr		thwes	t	9b. CIT	Ba1	timo		EATH		9c. COU	N/A	
- DIRECTOR		/A .		10c. CIT	10c. CITY, TOWN OR LOCATION Baltimore								10d. INSIDE CITY LIMITS? 1 1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER 2659 OSWEGO AV	enue			1.0		212	215				U.	
B	1 Never Married 2 N Married 3 Widowed 4 Divorced	NO								- American Indian, White, etc. by: Black			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) 8th	CATION completed) College (1-4 or 5+)		OECEOENT'S (Give kind of side. Do NOT us Cust	work done se retired.)	during mo	ON st of worldr	ng	City Schools				
BE COM	17. FATHER'S NAME (First, Middle, Lest) John Harrod									Middle, Maiden	Sumame)		
TO B	19a. INFORMANT'S NAME (Type/Print) Myrtle Harrod	19b. MAILING 2659	ADDRES	s (Street e	o A	or Rural	Aoute Nur	nber, City or Tow Balto.	n, State, Zip) . Code)	1215		
	20g. METHOD OF DISPOSITION 1 23 Burlal 2 Cremation 3 Remo 4 Donation 5 Other (Specify)			CEAND DATE	n FC	bres	t V		7/3	TE 20c. LC	cation — Vings	city or To	ls, MD.
	21. SIGNATURE OF FUNERAL SERVICE LICE	Hector	CFSP		E		Phi	llip	os I	F/H Ba	alto.	, M	Monroe St. D. 21217
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition recuiting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Approximate interval Between Onset and Death Sequence of: DUE TO (OR AS A CONSEQUENCE OF):												
PHYSICIAN: MEDICAL CI	PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. PERFORMED! 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PL	ACE OF OEAT	TH (Check	only one)		ERTAIN					
ВУ РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. OATE OF II (Month, Day	INJURY y, Year)	28b. TIM	E OF JURY M	28c. INJU WOI 1 Y	JRY AT RK? ES 2	/		er (Specify) SCRIBE HOW I	NJURY OCC	CUREO	
	3 Suicide 6 Could not be 4 Homicide datarmined	26e. PLACE OF building, at	INJURY — At rtc. (Specify)	home, ferm, s	itreet, fact	ory, office			26t. LO	CATION (Street or Town, State)	and Number	or Rural R	oute Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICI 2 MEDICAL EXAMINER												end manner ee stated.
O BE	246. SIGNATURE AND STILLED CERTIFIER	1					29c. LICE	SE NUN	MBER 29d. DATE ► 17			SIGNED	(Modth, Day, Year)
	ROBULT RESY	MDI			Print)								
	AUG 0 1 1995	32. REGISTRAR	's SIGNATURE	feet.									

10+1



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing and completely filled in by the funeral director, page 5 may be retained by the hospital or use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	HUDOGIANT 16 ton 30 to marked on them 30 absence and fallers as ables assent the second
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		1 - FOR STATE REGISTRAR		STATE OF M	IARYLAND	/ DEPAR	TMENT		EALTH AND		YGIENE EG. NO.	i		
		1. DECEDENT'S NAME (First,	HAI	berhorn	+ FRAN	K ALVIN	HABER	KORN		2. DATE OF I	DEATH DAY	301993	3. TIME OF DEATH 12:56 P	
		216-28-548	3	5. SEX 1 X M 2 - F	6. AGE (In yrs.	YRS.	MONTHS	DAYS	HOURS MIN.	7. DATE OF E (Month, Day NOV •	27,		THPLACE (State or Foreign ryland	
	TOR	90. FACILITY NAME (If not institution, give street and number) NURTH ARUNGEL HOSPITAL GEN BURNIE ANNE ARUNG RESIDENCE OF DECEDENT 90. FACILITY NAME (If not institution, give street and number) 90. COUNTY OF DEATH ANNE ARUNG												
	DIRECTOR	Maryland	Anne	Arundel			y, town o			lyn Par	k)		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
	FUNERAL	5109 Bal	lman A	venue		-		101	2122	5		10g. CITIZEN OF WHAT COUNTRY? USA		
	ה	11. MARITAL STATUS 1 Never Merried 2 X 3 Widowed 4 Divor		12. WAS DECEDENT FORCES? 1 IF YES, GIVE W KOrea A	YES 2	NO	1 1	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexicen, Puerto Ricen, stc.) 1 YES 2 X NO Specify: 1. ARCE — American Black, White, etc. Specify: Whit						
ei	COMPLETED	15. DECE (Specify only Elementary/Secondary (0- 12	DENT'S EDUC highest grade	CATION completed) College (1-4 or 5 + +4		DECEDENT'S (Give kind of a life. Do NOT us e CO.)	vork done of Peretired.)	during mo.	st of working	BGE		NESS/INDUSTRY		
o at once	BE CO	17. FATHER'S NAME (First, Mic Valentine	Johr	n Haber	korn			9	18. MOTHER'S NA	ame FRIE	DA CAT	HERINE MI	EYER 'er	
	2	Mrs. Kath		R. Haber	korn	19b. MAILING 5109	Bal	1mar	nd Number or Rural 1 Ave.,	Baltimo	ity or Town,	State, Zip Code) Md. 212	25	
r must n		20a. METHOD OF DISPOSITION 1 Burlet 2 Commetter 4 Donation 5 Other	n 3 🗆 Remo Specify)		Metr.	cremetory or or O	of disposi ther place) Ia tor	y,]	nc. 7/	31/95		ation — city or on on SV111	Town, State e, Maryland	
examine	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin E. Ecker McCully Funeral Home of Brooklyn													
Tour, tile medico		23. PARTY Enter the dis- shock, or he IMMEDIATE CAUSE (Find disease or condition resulting in death)	ert fellure.	complications that List only one cause a	ne on each i	deeth. Do nine.	ot enter	the mod	de of dying, suc	ch as cerdiec	or respira	atory errest,	Approximete interval Between Oneet end Death	
t or other naminance	CERTIFICATION	Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST b. CONOM A TONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): d.												
nows any inju	MEDICAL	PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert 1. DICTURE TO CAUSE OF DEATH YES INO UNCERTAIN P 24a. WAS AN AUTOPSY PINDINGS ANALIABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 INO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)												
10 10	PHTSICIAN:	1 YES 2 NO		HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER 4 Nurs	: Ing Home	5 🗆 Realdence					
K I	10	1 Natural 5 P	wnding westigation	28a. DATE OF I	y, Year)		M	_	RK? ES 2 NO	28d. DESCRIB	E HOW INJ	URY OCCURED		
	C I CU	4 Homicide de	ould not be etermined	28e. PLACE OF building, a	tc. (Specify)	home, farm, a	treet, fecto	ery, office		28f. LOCATION City or Tow	l (Street and vn, State)	d Number or Rurel	Route Number,	
Date of the contract of the co	COMPL	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) end manner ee stated.												
בן נ	2	200. MONANCINE AND PYPILE O	an	2 m	-				D3/	MBER) 4 4		DATE SIGNE	D (Month, Day, Year)	
1		30 NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	OF DEATH (I	TEM 27) (Type,	Print)							
		AUG VI	1995	Jalin da	roller Re	roball								
		A (T)											DHMH-1S Rev 1/89	

BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

urial-transit permit.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withous after death. Page 6 may be retained by the hospital or attending p	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the t	noval,	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ecuted within 24 hours	nd completely filled in by	burial, cremation, or rem	rtic event, the medi-
death certificate be exe	e attending physician ar	lental Hygiene prior to	ury, or other trauma
he law requires that the	has been signed by the	Dept. of Health and N	n 23 shows any inj
INDING PHYSICIAN: TI	R: After this certificate	er death with the State	is marked, or iter
HE HOSPITAL OR ATTE	HE FUNERAL DIRECTO	led within 72 hours after	ORTANT: If Item 28
2	5	8	E

4 DRY Donoro

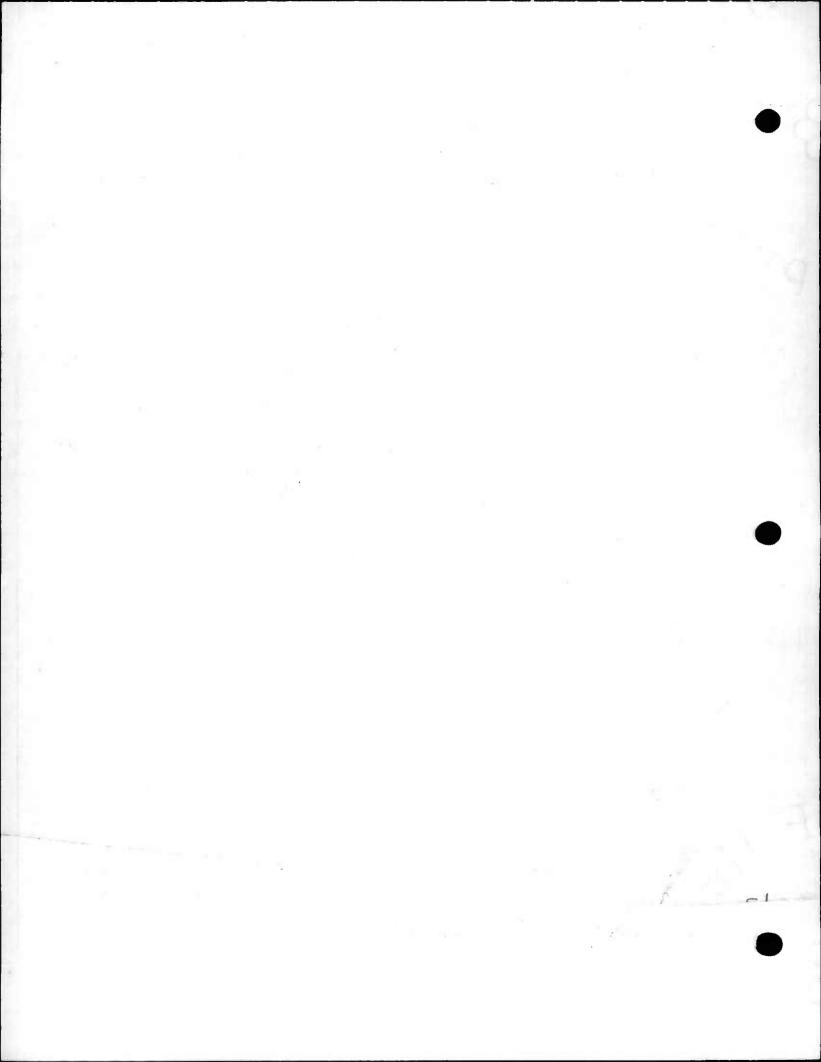
AUG 01 1995

1. Koren

3. REGISTRAR'S SIGNATURE

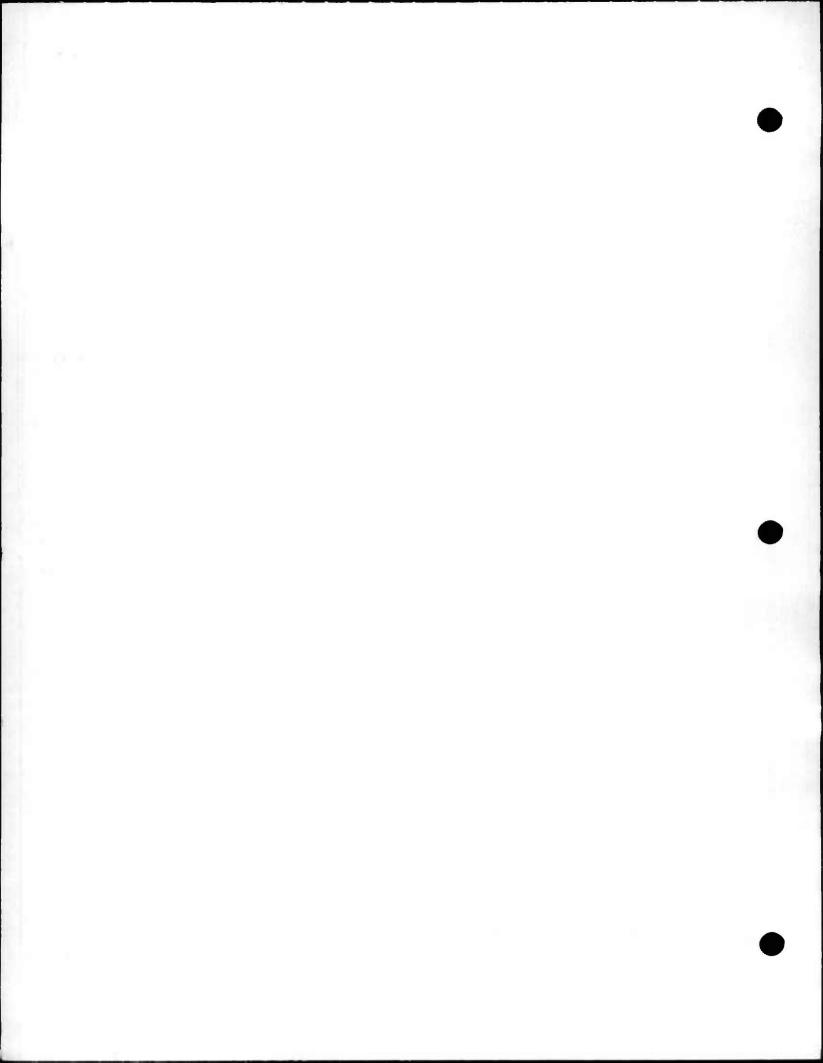
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -REGISTRAR **CERTIFICATE OF DEATH** 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF CEATH JULY 29 1995 BARBARA HURST 8:13 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign Feb. 21, 1947 1 M 2 KF Dist. of Columbia 217-46-3384 48 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN 186 LAKE SHORE DRIVE ANN ARUNDEL PASADENA DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Pasadena, 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 315 Maryland Ave. 21122 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.)
 O Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Specif White COMPLETED 15. DECEOENT'S EOUCATION (Specify only highest grade completed) 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) Planner Martin Marietta 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname, notified at Dorothy E. Jeffers George E. Hitcho BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Steve Hurst 7941 E. Shore Rd. Pasadena, Md.21122 3 20e, METHOD OF DISPOSITION

1 © Burlsi 2 Cremation 3 Ramoval from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Our Lady of the Fields Aug. 2,1995 Millersville, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY McCully Funeral Home THIX 3204 Mountain Rd. Pasadena, Md.21122 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart fallure. List only one cause on each line intarvai Between **IMMEDIATE CAUSE (Final** Onset and Death the disease or condition resulting in death) CIRABSIS ORLINER event, OUE TO (OR AS A CONSEQUENCE OF): injury, or other traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATN? 1 TYES 2 THO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 1X YES 2 NO 4 ☐ Nursing Home XXRaaldence 8 ☐ Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF 28d. OESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending М 1 YES 2 NO ВУ 2 Accident 28s. PLACE OF INJURY — At home, farm, streel, factory, office building, atc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be datermined 4 Homicide 29s. CERTIFIER
1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and menner as stated. 2 💢 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29d. OATE SIGNEO (Month, Day, Year) BE 29c. LICENSE NUMBER O.C.M.E ▶JULY 30,1995 2 who completed cause of Death green 27 (The Print) Street, Baltimore, Maryland 21201



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2 2 2	711	Prevost Charl	es Boyce			18. MOTHER'S NA Caroli		Middle, Malden Sumeme) Allen			
MA retain 5 sho	TO BE	190. INFORMANT'S NAME (Type/Print) Ms. Kathleen Bi	colou Forcus			and Number or Rural i	Route Number, City or To	Number, City or Town, State, Zip Code) 2121			
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Page 6	ner must	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE.	G	retery, cremetory or o breen Mou	nt Crema	TOTY NO ADDRESS OF FA	7/31 Ba	ltimore	e, Maryland		
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after 30 and 30	n 28 is ETED	4 Homicide 8 Could not be determined	building, etc. (Spec	cify)	area, ractory, orner		28f. LOCATION (Street City or Town, State	end Number or F	tural Houte Number,		
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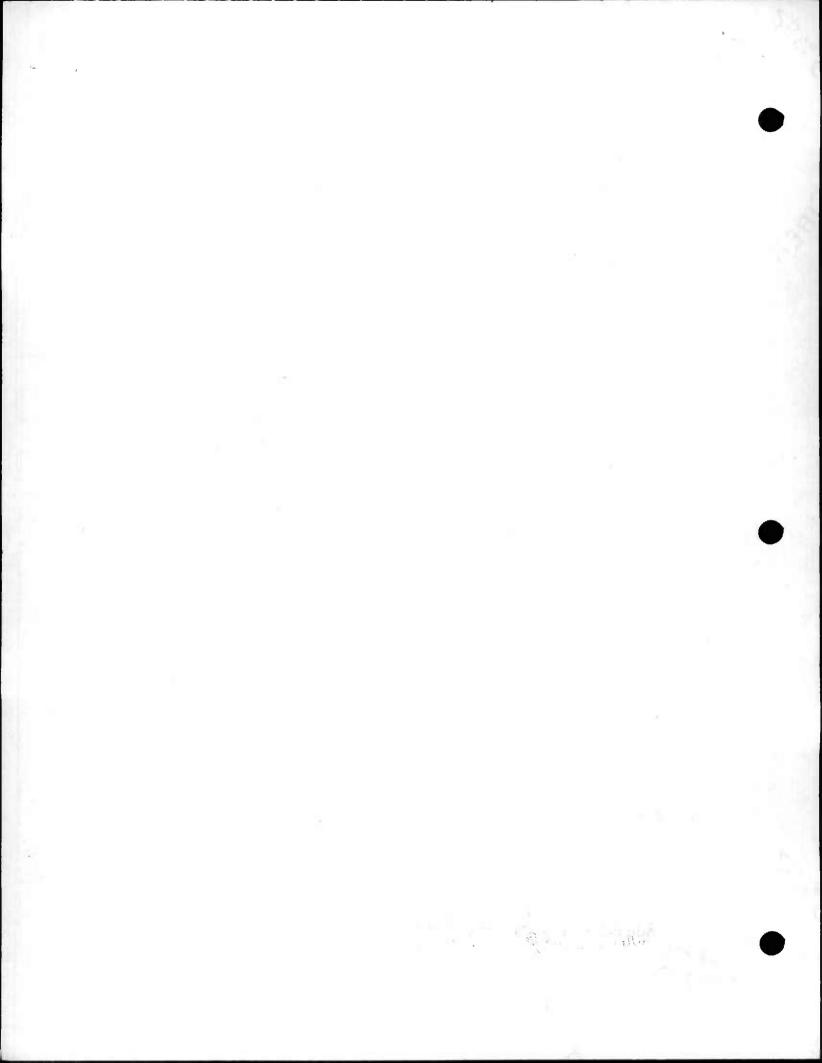
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DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DEPOSITION OF DEATH SEARCH STREET OF MEDICAL PLANKINGS. 1	that the safeth as	8	appene	prevar	Vita						NO	00	MPLETION OF CAUSE
25. PLACE OF DEATH (Check only displayed by the parties of the par	SEC equire of He			V						1			
The part of the pa	law las be Dept.	AN						UNCERTAIL	N				
The part of the pa	ITAN: The Cate the State	S	EXAMINER?	HOSPITAL:		OTHER:							
290. CERTIFIER (Check only one) 290. CERTIFIER (Check only one)	SICIAL Certific the the	¥									HIBY OCCUR	nen.	
290. CERTIFIER (Check only one) 290. CERTIFIER (Check only one)	PHY this with						WORK	?	200. DES	CHIBE HOW IN	JUNY OCCUR	EU	
290. CERTIFIER (Check only one) 290. CERTIFIER (Check only one)	NDING NDING IS M		3 Couleddo	28e. PLACE OF INJURY	— At home, fam	n, street, factor			281. LOC	ATION (Street a	nd Number or	Rural Rout	n Number,
20 CERTIFIER (Check only one) 20 MEDICAL EXAMINER: On the base of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 21 MEDICAL EXAMINER: On the base of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 22 MEDICAL EXAMINER: On the base of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 23 MEDICAL EXAMINER: On the base of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 24 Description on the base of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 25 Description on the base of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 26 Description on the base of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 26 Description on the base of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 27 Description on the base of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 28 Description on the base of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 29 Description of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 29 Description of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e	VIS ATTE	E 1	4 Homicide datermined	building, atc. (Spec	муј				City	or Town, State)			
296. LICENSE NUMBER 296. LICE		2	29e. CERTIFIER (Check only 1 CERTIFYING PHYSI	CIAN: To the beat of my know	ledge, death occ	urred at the tim	ne, date en	d place, end due	to the cau	se(s) end man	ner se stated.		
296. LICENSE NUMBER 296. LICE	NERA	O										euse(e) en	d menner ee stated.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) ALAN D. BEDLICK MD 9000 FreeWilling. W., Baym D 2/237 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	HE HO	шШ	296. AGNATURE AND TYPUE OF CERTIFIED	CHIEF, SEC	TION O) [-	2	9c. LICENSE NUM	WBER		29d. DATE SE	QNED (M	ingh, Day, Year)
ALAN D. BEDLICK MD 9000 Franklin Sq. W., Ba GOMD 21237 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE			Aller Velle					D42	595		1	128	195
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE		- 1	30. NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE OF DE				%	D.	1 1	-	1	
	ļ		31 DATE FILED (MODIFIE CON MODIFIE	CKMD 90		centle	2)8.	W.	pa 6	PMD	212	-37	-
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
1

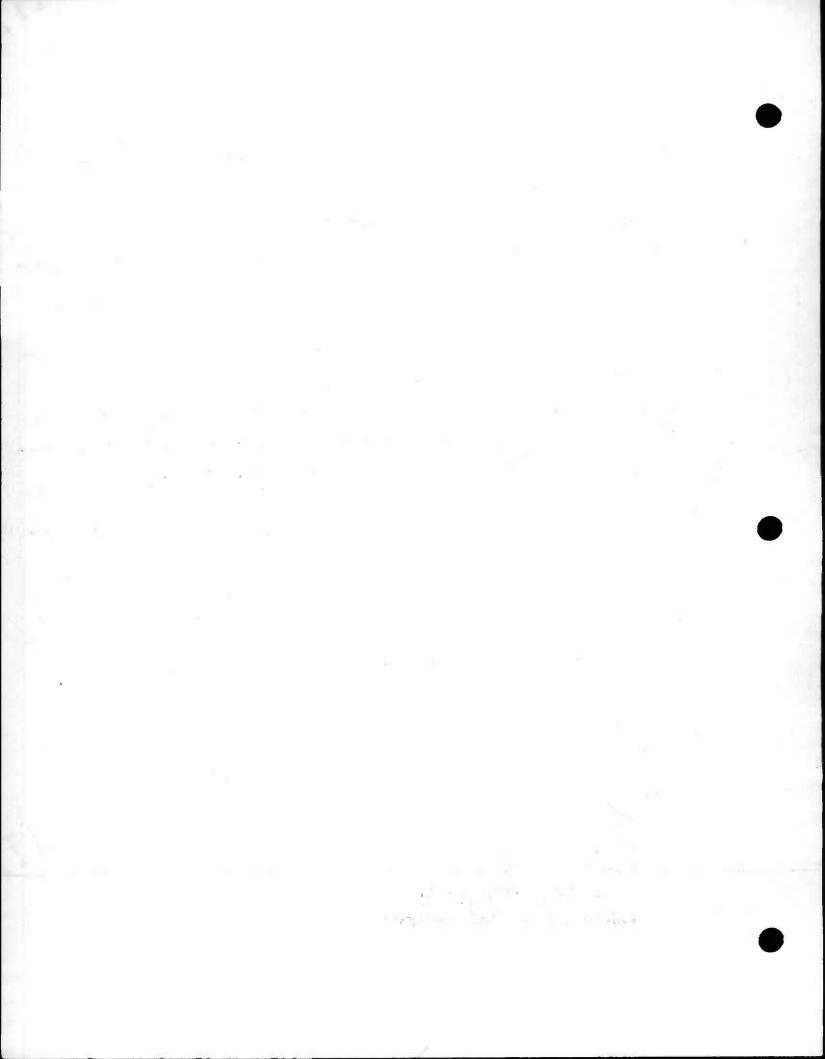
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	FOR 1 - STATE REGISTRAR	STATE OF MA				EALTH AND DEATH		YGIEN EG. NO.	E			۳.
	1. OECEDENT'S NAME (First, Middle, Last)		-				2. DATE OF D	EATH DA		YEAR	3. TIME OF DEAT	ГН
	Jeffrey	R.	Hout				July 2	28,	1995	TEAN	9:25	рм
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last birth	MONTHS	ER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BI (Month, Day,	RTH Year)		8. BIRTH Countr	PLACE (State or Fo	oreign
	218-88-5505	1 🖾 M 2 🗌 F	34 Y	RS.	DATS	HOURS MIN.	Mar 29,	19	61		ryland	
	9a. FACILITY NAME (If not institution, give s	street and number)		9b. CI1	TY, TOWN	OR LOCATION OF D				NTY OF D	EATH	
<u>6</u>	1515 Winding B	rook Way		V V	Vood1	awn				Ba:	ltimore	
ည် မြ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y	100	c. CITY, TOWH	ORLOCA	LION						
DIRECTOR	Maryland	Baltimore			odla				10d. INSIDE CITY			
	10e. STREET AND NUMBER					I. ZIP CODE			100 0171	TEN OF H	1 YES 2X	NO
FUNERAL	1515 Winding Br	ook Wav				21244				S.A.		
Š	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. ARMED	11	WAS DEC	ENDENT OF HISPAI	MIC ODIGINA /Pa	olfu Vo			American India	
	1 🔀 Never Married 2 🗌 Married	FORCES? 1 I	YES 2 NO		If yes, sp	ecify Cuban, Maxica 2 25 NO Specif	in, Puerto Rican,		0/ NO_	Black	, Whita, atc.	uri,
B	3 Widowed 4 Divorced			у.			Specia	White				
ᇤ	15. DECEOENT'S EDU (Specify only highest grade	CATION completed)		NT'S USUAL			18b, KIND	OF BUS	INESS/IND	USTRY		
ш	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do N	IOT use retired.)	at or trotting						
COMPLETED		8 Years	Ph	armaci	st			_		g Sys	stems	
	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA		Maiden .	Sumame)			
H	William 19a. INFORMANT'S NAME (Type/Print)	Hout				Rita						
၉		v. 1				and Number or Rural						
	Mr. Thomas 1	Maykrantz				Brook Wa			n, Ma			44
	1 Burial 2 Commation 3 Ram 4 Donation 5 Other (Specify)	oval from State	20b. PLACE AND D	v or other place	al le		1		CATION —			1
	21. SIGNATURE OF PUNERAL SERVICE LIC	DENSEE /	Calloli			Service		нап	npste	ad,	Maryland	<u>d</u>
- 1	· Stale	In a	1	s I	orin	g Byers	Funeral					
-	requer	- 111	enper	5 8	3728	Liberty	Road R	land	allst	own,	MD 211	33
	23. PART I. Enter the diseases, or a shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause	on each line.	Do not ente	or the mo	de of dying, auc	h an cardiac o	r reapli	ratory arr	est,	Approximatinterval Bellinterval Bellinterval Bellinterval	etween
		DUE TO (OF	AS A CONSEQUEN	CONSEQUENCE OF):							100	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that included exercised exer											
	that initiated events oue to (or as a consequence of): resulting in death) LAST											
	PART II. Other aignificant condition	a contributing to de	ath hut not recult	line in the c			m 4 1					
PHYSICIAN: MEDICAL			and bot frot regul	ang m the t	maonym	a canse diven iti		PERFOR		245.	WERE AUTOPSY FIR AMAILABLE PRIOR 1 COMPLETION OF C	TO
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Σ	DID TOBACCO USE CONTI	DIRLITE TO CALL	E OF DEATH	VEC 🗆	NOY	LINICEDTAL					1 YE\$ 2 N	10
ĕ ∥	25. WAS CASE REFERRED TO MEDICAL	KIBOTE TO CAOS	28. PLACE OF		NO X	UNCERTAI	и 🗆					
	EXAMINER?	HOSPITAL:		OTHE	R:	-/	_					
Ě	27. MANNER OF DEATH	28a. DATE OF INJ		TIME OF	28c. INJ	6 5 Basidence	8 Other (Spec					
	1 Aletural 5 Pending	(Month, Day,)		INJURY	Wo	RK?	200. DESCRIBE	. HOW IN	IJUNY OCC	UHED		
B	2 Accident Investigation 3 Suicide & Could ext be	28a. PLACE OF IN	JURY At home, fa	erm, atreel, fac			28f. LOCATION	(Street a	nd Number	or Bural B	oute Number	
2	4 Homicide 8 Could not be	building, alc.	(Specify)				City or Town	n, State)	no rumbor	or more re	outo ruman,	
ן ב	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my	knowledge death or	terrored at the	Alma duta	Salata Valla	575					-
COMPLE	(Check only one) 2 MEDICAL EXAMINE										and menner se et	mad
- 11	29b. SIGNATURE AND TITLE OF CERTIFIER				1			, чис				mied.
N N	(Sdui 91	ion	2			29c, LICENSE NUN	378-	- 1	29d. DATE	SIGNED	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE O	OF OEATH (ITEM 27)	(Type, Print)		200	100		- 1	121	112	
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR RUTH 26, 8:13am w July HODAS 1995 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) Sept. 6,1913 6. AGE (In yrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 M 2 TE F 81 YRS. 110-10-3406 RUSSTA Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 9366 MELLENBROOK ROAD COLUMBIA HOWARD 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY NEW YORK BROOKLYN KINGS 1 X YES 2 | NO detached for use as the burial-transit permit, FUNERAL 10a STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 1064 E. 12th STREET 11230 USA in EX hours after death. Page 6 may be retained by the hospital or attending physician, tely filled in by the funeral director, page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 1 NO Specify: 14. RACE — American Indian, Black, Whita, etc. 1 Never Married 2 Married BY Specify: 3 N Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ost of working Elementary/Secondary (0-12) College (1-4 or 5+) MACHINE OPERATOR CLOTHING 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) DAVID BE LIEBENSON DORIS UNKNOWN notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DR. JORDAN TOBIN 9336 MELLENBROOK RD. COLUMBIA, MD 21045 pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1 M Burial 2 Cremation 3 N Removal from State N.Y NEW MONTEFIORE 4 ☐ Donation 5 ☐ Other (Specify) 7+27-1995 PINELAWN, L examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. in by the f 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, medicai filled in by 1 Approximete interval Between shock, or heart failure. List only one cause on each line. 0 **IMMEDIATE CAUSE (Finel** Onset and Death cremation. traumatic event, the disease or condition WIDELY METASTATIC BRONCHOGENIC CARCINOMA 6 Minays completely resulting in death) DUE TO (OR AS A CONSEQUENCE OF): burial, CERTIFICATION and Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING physician other 1 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events attending resulting in death) LAST Mental PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS signed by t AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? UNGESTIVE HEART FAILURE any 1 TYES 2 NO shows : 1 TYES 2 NO peeu jo DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 certificate has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem State HOSPITAL: 1 YES 2 NO 1 Inpetiant 2 I ER/Outpetient 3 I DOA 4 - Nursing Home 5 Rasidenca 6 D Other (Specify) Ö the 27. MANNER OF DEATH 28c. INJURY WORK? 28a. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF marked, WITH THIS Natural 5 Pending ВҰ 1 YES 2 NO death After 2 Accident 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is DIRECTOR: / COMPLETED 8 Could not be 4 Homicide tem 29a. CERTIFIER ledge, death occurred at the time, date and place, end due to the cause(a) and manner as stated. FUNERAL C Ξ TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 29b. SIGNATURE A BE 2



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF H	EALTH AND	MENTAL HYGIEN		
	1. OECEDENT'S NAME (First, Middle, Last) RUTH	G. I	LEY			2. DATE OF DEATH MONTH	w31 a	3. TIME OF DEATH 2:30pm
1000	4. SOCIAL SECURITY NUMBER 5.		n yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan 31, 1		BIRTHPLACE (State or Foreign Country) Maryland
Œ	9a. FACILITY NAME (If not institution, give street Lorien-Frankfort	Y OF DEATH						
CTO	RESIDENCE OF DECEDENT	Tide Tilly Oction			imore		N/A	
DIRECTOR	Maryland N/A			altimore				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	100. STREET AND NUMBER 4028 Hickory	Avenue		101	21211		U.S	N OF WHAT COUNTRY?
В	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 VES IF YES, GIVE WAR OR DA	2 NO	If yes, sp		NIC ORIGIN? (Specify Yes an, Puerto Rican, atc.) fy:		Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S EQUCATI (Specify only highest grade con Elementary/Secondary (0-12) UNKNOWN	ION inpleted) College (1-4 or 5+)		USUAL OCCUPATION ork done during mode retired.) USEWIFE	ON st of working	16b. KIND OF BU		TRY
	17. FATHER'S NAME (First, Middle, Last)	Edelman			18. MOTHER'S NA	AME (First, Middle, Meiden a Cook	Sumame)	
BE	19e. INFORMANT'S NAME (Type/Print)	Baciman	19b. MAILING	AOORESS (Street a		Route Number, City or Tow	n, State, Zip Co	ode)
5	Doris Garrett		4028	Hickory	Ave, Ba	ltimore, M	d. 212	11
	20. METHOD OF DISPOSITION 12 Buriel 2 Cremation 3 Removal 4 Donation 5 Other (Specify)		PLACEAND DATE Of the Property of the Lake Vie	w Mem Ga	ardens	8/4/95 S		y or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICENS A. Ala	Seit (2	A. A. 3818	Roland .	z, Jr. Fun Avenue, Ba	ltimore	e, Md 21211
	23. PART i. Enter the diaeaaea, or com ahock, or heart failure. Llat	pilcationa that caused t only one cause on ea	the death. Do n ch line.	ot enter the mo	de of dying, aud	ch as cardiac or reap	ratory arrest	t, Approximata Interval Between
	IMMEDIATE CAUSE (Final disease or condition reaulting in death)	ATHELISCLE	PROTIC (CORONA	LY HEAH	RT DISEAS	હ	Onset and Death
z		DOE TO (OR AS A	CONSEQUENCE OF):				
CATIO	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS A	CONSEQUENCE OF):				
CERTIFICATION	CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):			_	
CC	PART II. Other aignificant conditions c	ontributing to death bu	it not reaulting is	n the underlying	cause given in	Part I. 24a. WAS AN	ALITOPSV	24b. WERE AUTOPSY FINDINGS
EDICAL	BREAR COLL	CARRINO) EMEN		PERFOR	RMEO?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?
PHYSICIAN: MEDI	DID TOBACCO USE CONTRIB		DEATH YE	S 🗆 NO 🗆	UNCERTAI	N D		1 Tes 2 No
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	6. PLACE OF OEAT					
14S	1 VES 2 NO 1 E	Inpatient 2 ER/Outpa	tlant 3 DOA	Nursing Hom		6 Other (Specify)	N. III. OOGUA	
BY P	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJU	JRY WO	RK?	200. DESCRIBE HOW I	NJUHT OCCUR	EU
2 Culate 1 288. PLACE OF INJURY _ At home form street fection office 1 004 (0047104) (00474 and 10 4474 and 10 4744							Rural Route Number,	
COMPLETED	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN MEDICAL EXAMINER: Q							ause(a) and manner as stated.
	29b. SIGNATURE AND STATE OF CERTIFIER			1	_29c. LICENSE NUI			IGNED (Month, Day, Year)
TO BE	J.N. PM),			D+1-	291	▶ ₹	31 95
	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type,		00.05	(B) V (1 .	
	31. OATE FILEO (Month, Day, Year) AUG 0 1 1995	THE STATE SIGN	and the		DRIVE	ONINGS	nice	FI116 04, 3
II)	MU 0 - 1000 (/							

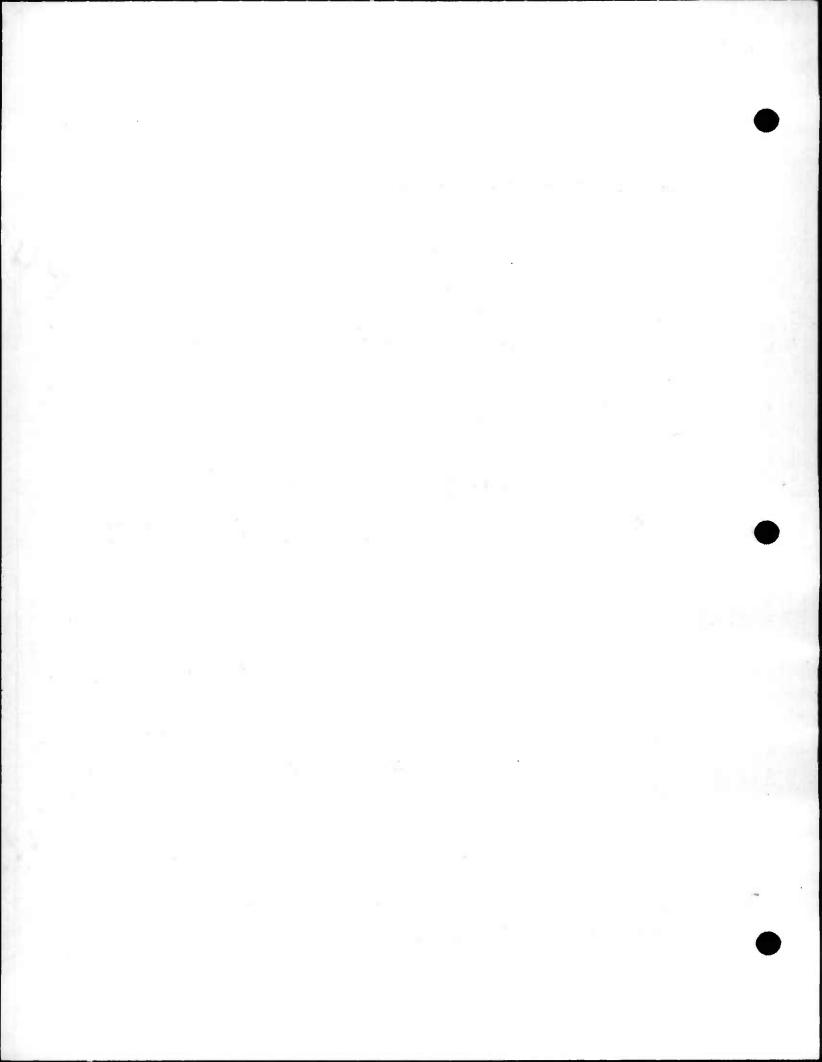
31. DATE FILED (Month, Day,

32. REGISTRAR'S SIGNATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 MICHAEL **JACOBS** JÜLY 27 2:04 PM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 217-84-5561 1 X M 2 - F Oct 196 18, hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH A DIRECTOR N OF 346 DIVISION STREET BALTIMORE 10a. STATE 10c. CITY, FOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 | NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITJZEN OF 21217 420 Ave U.S. uid WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 12. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yee, specify Cuban, Mexicen, Puarto Rican, etc.)
 NO Specify: BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried Specify Black BY 3 Widowed 4 Divorced BE COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY tary/Secondary (0-12) College (1-4 or 5+) Custodian College once. 17. FATHER'S NAME (First, Middle, Last) 18_MOTHER'S NAME (First, Middle, Maiden Sumame) notified at acobs 0 00 19a. INFORMANT'S NAME (Type 19h, MAILING ADDRESS (Street Or Runal Route Ave 2 Balto, md 1420 21217 nnie Druid Pe 20a METHOD OF DISPOSITION
1 Burlai 2 Cremation
4 Donattor 5 Other (Spe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must ☐ Cremation 3 ☐ md matory 2 other place) 5 Other (Specify) ansdowne examiner OF FUNERAL SERVICE LICEN 22. NAME AND ADDRESS OF FACILITY H-west marh 6 300 filled in by the fillen, or removal. wabash Are medicai 23. PART I. Inter the diseases, or complications that cause the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate nock, or haart fallure. List only one cause on intarval Between Onset and Death IMMEDIATE CAUSE (Final other traumatic event, the cremation disease or condition signed by the attending physician and completely Health and Mental Hygiene prior to burial, crematic resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complet be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crer IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated aventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 | NO YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO UNCERTAIN [25. WAS CASE REFERRED TO MEDICAL 26, PLACE OF DEATH (Check only one) XXYES 2 NO 5 Residence 6 Nother (Specify) Inpatient 2 - ER/Outpatient ON STREET 4 Nursing Home 27. MANNER OF DEATH 26b. TIME OF 28c. INJURY AT WORK? 28a, DATE OF INJURY 26d. DESCRIBE HOW INJURY OCCURED 1 Netural 1 YES BY C 2 Accident 26a. PLACE OF INJURY - At h 261. LOCATION (Street and Number or Rural Route Number, Suicide COMPLETED 4 Homicide determined 29a. CERTIFIER (Check only ath occured at the time, data and place, and due to the ceuse(s) and manner as stated, SIGNATURE AND TITLE OF CERTIF 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day, Year O.C.M.E. JULY 28, 1995 2 DEATH (ITEM 27) (Type, Print)

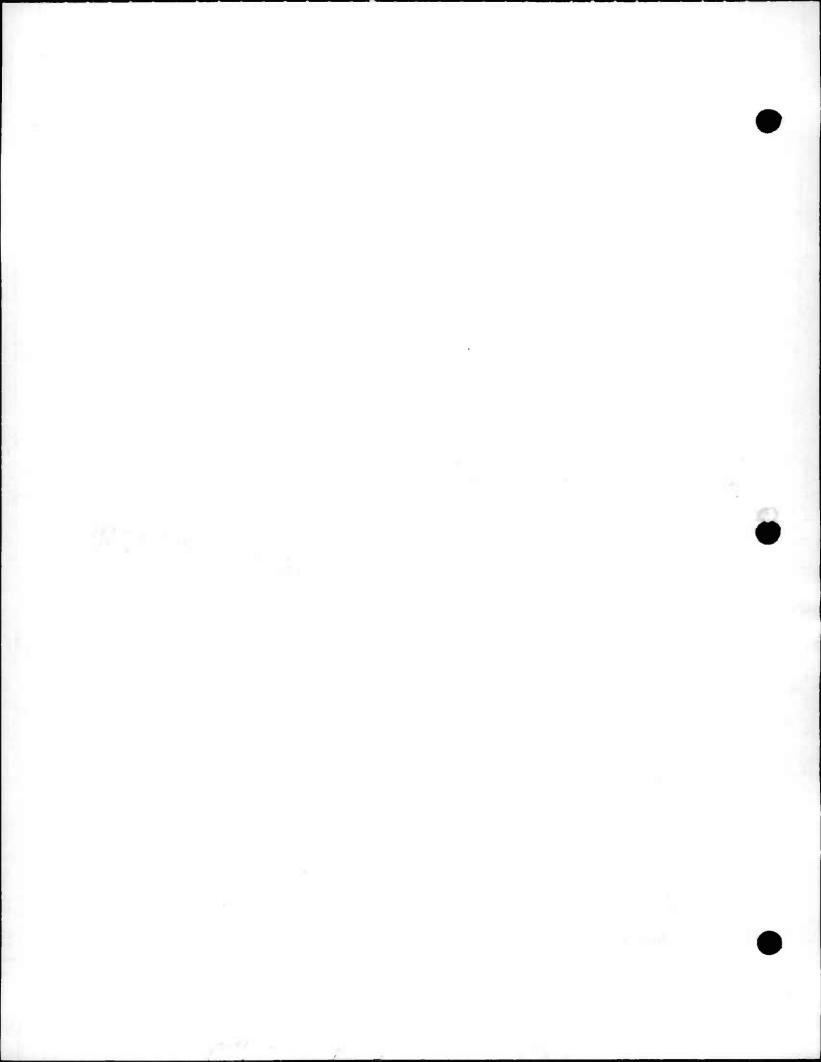
DHMH-16 Rev 1/89

Penn Street, Baltimore, Maryland 21201



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

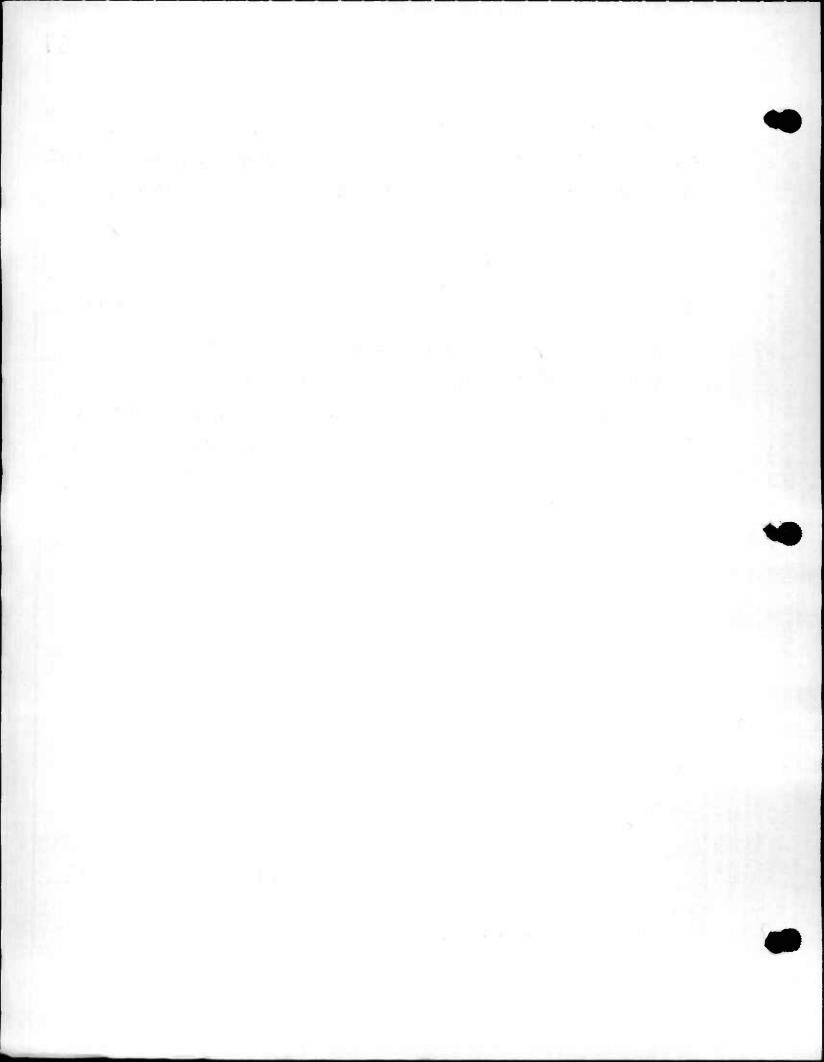
		1 - STATE OF MARYLAND / DEPARTMENT OF CERTIFICATE OF	HEALTH AND I	MENTAL HYGIEN		
		1. DECEGENT'S NAME (First, Middle, Last)		2. DATE OF DEATH	AY YE	3. TIME OF DEATH
		Rose M. Jones			995	11:06 AM
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	0	HRTHPLACE (State or Foreign ountry)
pino		214 03 7497 1 \square M 2 \searrow F 80 YRS. MONTHS DAYS 98. FACILITY NAME (If not institution, give street and number) 99. CITY, TOWN		July 18,19		ryland
3 sho	E.	John Hopkins Bayview Medical Center Baltim	OR LOCATION OF DE	EATH	9c. COUNTY	
1, 2,	210	RESIDENCE OF DECEDENT	lore		n/a	à
Pages	DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCA	ATION			10d. INSIDE CITY LIMITS?
mit.		Maryland Baltimore Essex 10e. STREET AND NUMBER	DI. ZIP CODE		I and in the same	1 TES 2 NO
physician. burial-transit permit. Pages 1, 2, 3 should	FUNERAL	211 Homberg Avenue	21221		10g. CITIZEN	OF WHAT COUNTRY?
physician, burial-trar	NO.	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DE	CENDENT OF HISPAN	IIC ORIGIN? (Specify Yes	or No.— 14. 1	U.S.A. RACE — American Indian.
	BY F		pecify Cuban, Maxica S 2 ZNO Specify			Black, White, atc. Specify:
attending se as the	ED E					White
6 2	ETE	(Specify only highest grade completed) (Give kind of work done during m	ton tost of working	16b. KIND OF BU	SINESS/INOUST!	RY
76 A	IPL	Elementary/Secondary (0-12) College (1-4 or 5+) Housewife		Own	Homo	
e de p	COMPL	17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NA	ME (First, Middle, Maiden		
a a a	BE (Guseppe Petroniero	Assur		otta	
retained by 5 should be notified at	2	19s. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street				
		ROSEMARY Hromada 614 Winslow				
leath, Page 6 may be funeral director, page xaminer must be		20e. METHOD OF DISPOSITION 1	7/31/		CATION — City of	
Page ral din		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME A	ND AGORESS OF FAC	ineral Home	сшюге	Maryland
death. Pag tuneral dir I. examiner						3 3 04004
hours after death, Page 6 may be ed in by the funeral director, page or removal. medical examiner must be		23. PART Lienter the diseases, or compile tions that caused the death. Do not enter the mo	ode of dving, such	ve Baltink	ore Mar	yland 21221
filled in on, or re		Jehock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final	Δ. Δ.	-Da. W.	all	Approximate interval Between Onest and Death
		diagona on any distant	Moly	soff war	-D 00	NA E
completely fille ial, cremation, event, the		resulting in death) a. Closed Head Injury Due to (or as a consequence or):	DO A	DPRNV	- D-U	MIT days
	N	Sequentially list conditions,				
e be execut sician and c rior to buris traumatic	CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING		A BOOK WAS IN STREET	No. of Parties of the	West of the second
physiene pre	임	CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):	TOTAL SECTION AND ADDRESS OF THE PARTY AND ADD	A DOSE WALL OF THE PARTY OF THE		
th cert ending Hygik	H	resulting in deeth) LAST	77.52			
e death he att	- 1	PART II. Other algnificent conditions contributing to death but not resulting in the underlyin	an anuan ahan In I	B	т	
d by t and my in	MEDICAL	Stroke	ig ceuse given in i	PERFOR	MEO?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
signe Signe Health	ED	Myocardial Contusion		1 YES 2	X NO	OF DEATH?
w required been of of sho		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO	UNCERTAIN			1 TYES 2 NO
The laste has the Degree of 22	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one)		, 0		
rtifical re Sta	YSI	OTHER:	ne 5 🗆 Rasidence	8 Other (Specify)		
his ce with th	F	(Month, Day, Year) INJURY W	JURY AT ORK?	28d. DESCRIBE HOW II		BY CAR
After t Jeath mar	BY	2 X Accident Investigation 7 4 - 95 7209 11		1522 CEN (CEN		TO STRUCE
TOR: /	ED	3 Suicida 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	ca	28f. LOCATION (Street a	and Number or Ru	rail Route Number,
OR AI DIREC Nours	9	29a. CERTIFIER 1 D'CERTIEVING BUYSICIAN, T. C. C. C. C. C. C. C. C. C. C. C. C. C.		KX. 702.	+ Hor	nlry ane.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to IMPORTANT: If Nem 28 is marked, or New 23 shows any Injury, or other traus	COMPLETE	(Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data one) 2 MEDICAL EXAMINER: On the basis of axaminstion and/or investigation, in my opinion, or				se(a) and manner as stated.
E FUN E FUN BITAN	E C	29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUM			NED (Month, Day, Year)
MP Se TH	w	716.115		852		31, 1995
	2	30. NAME AND ADDRESS OF ERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		Bayvien Me	dicalC	enter
		MOWALL SI RAUFMAN 494		n Ave Ba		
		31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE				
L		AUG 0 1 1995 Juli Stewarter Robert			-	
						OHMH-16 Rav 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the four after death. Page 6 may be retained by the hos TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	h. Page 6 may be retained by the hos	eral director, page 5 should be detach	niner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill held written 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation IMPORTANT: If Ilem 28 is marked, or Item 23 shows any Injury, or other traumatte event, the	rours after dea	ied in by the fur i, or removal.	medical exa
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exe TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician an be fised within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to b IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traums	cuted within	d completely fill urial, cremation	tic event, the
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attent he filed within 72 hours after death with the State Dept. of Health and Mental HIMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or	certificate be exe	Jing physician an lygiene prior to b	other trauma
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires TO THE FUNERAL DIRECTOR: After this certificate has been sign be fied within 72 hours after death with the State Dept. of Healt IMPORTANT: If Ilem 28 is marked, or item 23 shows	that the death	ed by the attend	any Injury, or
TO THE HOSPITAL, OR ATTENDING PHYSICIAN: T TO THE FUNERAL DIRECTOR: After this certificate he filed within 72 hours after death with the Stat IMPORTANT: If Item 28 is marked, or Ite	he law requires	e has been sign e Dept. of Heat	m 23 shows
To the Hospital or attending to the Funeral director: Afte be filed within 72 hours after deat Important: If Item 28 is im	PHYSICIAN: T	r this certificate h with the State	arked, or Ite
TO THE HOSPITAL TO THE FUNERAL I Be filed within 72 #	OR ATTENDING	DIRECTOR: After Jours after death	tem 28 Is ma
	TO THE HOSPITAL	TO THE FUNERAL De filed within 72 t	IMPORTANT: If I

	1 - FOR STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTH AND	MENTAL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	JAMESO	N		2. DATE OF DEATH MONTH DAY	SEAR 6, 10 M		
	4. SOCIAL SECURITY NUMBER 114-12-3316	1 M 2 X F	8 YRS. MON		7. DATE OF BIRTH (Month, Day, Year)	8. BIRTNPLACE (State or Foreign Country) Waw Castle, PA.		
TOR	9. FACILITY NAME (If not institution, give str 3/20 RAMS GAT RESIDENCE OF DECEDENT	TE DR.	WNAPOLIS	9c. COUNTY OF DEATN A.A. Co				
DIRECTOR	10a. STATE 10b. COUNTY	-A-Co.	10c. CITY, TO	WAPOLES		10d. INSIDE CITY LIMITS? 1 X YES 2 \(\text{NO}\) NO		
FUNERAL	3720 RAMS G	ATE DA.		101. ZIP CODE 21403		CITIZEN OF WHAT COUNTRY?		
BY FUI	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	13. WAS DECENDENT OF NISPA If yes, specify Cuben, Mexico 1 YES 2 NO Specifi	in, Puerto Rican, etc.)	b— 14. RACE — American Indian, Black, White, etc. Specity:		
COMPLETED	15. DECEDENT'S FOUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	16a. DECEDENT'S USU (Give kind of work life. Do NOT use ret	done during most of working	16b. KIND OF BUSINES			
OMP	17. FATHER'S NAME (First, Middle, Last)		DESIG	18. MOTNER'S NA	HOTELS			
BE C	RUFUS C.	PATTERSON		FRAN	ICES BUG	SH		
2	DAVID PATTER	SON	37201	PAMS GATE DI	- ANNAPOL	15, MD. 21403		
	20s_METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo 4 Donation 6 Other (Specify)	rval from State	other place)	N (Name of cometery, cremetory or	51995 NEW	ON - City or Town, State O ASTLE PA		
	21. SIGNATURE OF TUNERAL SERVICE LICE). Ska	eleh.	SKARDA F.	2829 HU	DSON 57. MD. 21224		
	23. PART I. Enter the diseases, or shock, or heart failure. I	omplications that cause lat only one cause on e	d the death. Do not e	enter the mode of dying, suc	h es cerdiec or respirator	Interval Between		
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	. Carcin	O MA	of the lur	Lq	3mos'		
NOI	Sequentially list conditions, if any, leading to immediate		CONSEQUENCE OF):					
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	A CONSEQUENCE OF):					
	PART II. Other significant conditions	. contributing to death h	uit not moulting in th	no underbine seuse elsen le	Part I. 24s. WAS AN AUTO	DPSY 24b. WERE AUTOPSY FINDINGS		
PHYSICIAN: MEDICAL	COPD	contributing to death t	or not resulting in a	is underlying cause given in	PERFORMED	? AMAILABLE PRIOR TO COMPLETION OF CAUSE		
AN:	25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATN (C	had and and			
SICI	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Out		THER: Nursing Home 6 Residence		. 50		
FH	27. MANNER OF DEATN 1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF		28d. OEŞCRIBE HOW INJUR	Y OCCURED		
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Spe	Y — At home, farm, stree		281. LOCATION (Street and N City or Town, State)	lumber or Rural Route Number,		
COMPLETED	CONSTRUCTION OF THE STATE OF TH			t the time, data and place, and du		as stated. s to the cause(a) and manner as stated.		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	n arap	Q	0452	MBER 290	1. DATE SIGNED (Month, Day, Year) 7-31-95		
2	30. NAME AND ADDRESS OF PERSON WHO	completed cause of De	EATN (ITEM 27) (Type, Pric	Ridgely A	ve Suite	131 Anna 20115		
	31. DATE FILED (Morith, Day, Year) AUG 0 1 1995	32. REGISTRAR'S SIGN	NATURE NAVILLA	Total of the		WO 51401		





		FOR 1 - STATE REGISTRAR	STATE OF MAR	YLAND /	DEPAR ERTIF	RTMENT	OF H	EALTH AND	MENTAI	L HYGIEN	E		
		1. DECEDENT'S NAME (First, Middle, Last)	GERTRUDE SU		AN				2. DATE MONTH	of DEATH	199	YEAR	3. TIME OF DEATH 1:00 AM M
		4. SOCIAL SECURITY NUMBER	5. SEX 8. A	GE (in yrs. les	st birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTN			PLACE (State or Foreign
pino		219 ≈ 22 ≈ 1966 9s. FACILITY NAME (# not institution, give s	1 M 2 F	81	YRS.				Nov	. 20,1		Vi	rginia
2, 3 should	стов	Johns Hopkins Bo		cal C	tr.			or location of di timore C			9c. COU	NTY OF D	
, sec. 1.	Ē	10a, STATE 10b, COUNTY	Y		10c, CIT	Y, TOWN C	R LOCAT	TION					10d, INSIDE CITY
permit. Pages	DIRE	Maryland	Baltimor	e				Dur	ndalk				LIMITS?
	FUNERAL	10e. STREET AND NUMBER					101	. ZIP CODE			10g. CITI		VHAT COUNTRY?
020 physician. burial-transit	NE NE	1725 Rita Road 11. MARITAL STATUS	12. WAS DECEDENT EVE	RINUS AR	BMED.	19.9	MAS DEC	ENDENT OF HISPAI	21222		11-		ted States
-0020 ling physician the burial-tra	BY FL	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 7	ES 2 X		'	f yes, spe	ecify Cuben, Mexica 2 NO Specif	n, Puerto F		or No-	14. RACE Black Specif	- American Indian, t, White, atc.
1215-0 r attending use as the		15. DECEDENT'S EDU		16a, DE	CEDENT'S	USUAL O	CUPATIO	ON ast of working	16b.	KIND OF BUS	INESS/IND	USTRY	Wilde
the hospital or detached for u	COMPLET	Elementary/Secondary (0-12) 9 Years	College (1-4 or 5+)	life	. Do NOT u	so retired.)		st of working		C	wn H	ome	
# 2 € ₹	ш	17. FATNER'S NAME (First, Middle, Last) NOT KNOWN	Elder					18. MOTHER'S NA	ME (First, A	fiddle, Maiden			
be retained to ge 5 should a notified	TO B	190. INFORMANT'S NAME (Type/Print) James Michael Jo	ordon	19				and Number or Rurel					d 21222
		26s METHOD OF DISPOSITION 1 S Burfal 2 G Gremation 3 G Ram 4 G Donation 8 G Other (Specify)	ovel from State	20b. PLACE	ANDDATE	OF DISPOS	ITION /Na		DATE	20c LOC	CATION -	City or To	
BALTIMORE, after death. Page 6 may be noval. cel examiner munt be		21. SIGNATURE OF PURERAL SERVICE LIC	ENSEE /	1	1	22.	name an Duda	ID ADDRESS OF FA	cility Mera	l Home	06	Dund	alk, Inc.
B) after of moval.		23. PART I. Enter the diseases, pr	complications that car	and the de	with Do	not enter	7922	Wise Au	10.	Dundal	k, M	aryl	
in 24 hours by filled in thation, or res the media		shock, pr heart failure. IMMEDIATE CAUSE (Final disease pr condition resulting in death)	List Dniy Dne cause D	n efach iine	D			gar cin			ratory err	est,	Approximate interval Between Onset and Daath
OX 68760 be executed with sician and complete rior to burial, cremtraumatic event	FICATION	Sequentially list conditions, if any, leading to immediate	b. DUE TO (OR /	LOS A CONSEC	TOS OUENCE O	\$ 6 S		40	Bro	210	1		
BO ate be hysicial prior	CAT	cause. Enter UNDERLYING CAUSE (Disease or Injury	С.										
S, P.O. B(death certificate attending physiental Hygiene pri	CERTIF	that initiated events resulting in deeth) LAST	DUE TO (OR AS A CONSEQUENCE OF):					-					
0 0 4 3	AL C	PART II. Other significant condition	s contributing to deat	h but not r	resulting	In the un	derlying	ceuse given in	Part i.	24s. WAS AN	AUTOPSY	24h.	WERE AUTOPSY FINDINGS
that the the the and the and i	MEDICA								_	PERFOR			AMAILABLE PRIOR TO CDMPLETION DF CAUSE OF DEATN?
	Σ.	DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEA	TH YE	S 🗆 N	40 D	UNCERTAIL	MA				1 YES 2 NO
TAL The law ate has t tate Dept	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				TN (Check o		ONCERIAII	ALI				
ICIAN: The sertificate the State or item	YSIC	1 - YES 2 NO	1 Department 2 ER/O	Outpatient 3	□ DOA	OTHER 4 Num		s 5 🗆 Residence	8 🗆 Other	(Specify)			
NG PHYSIC fler this ce eath with th	ву РНУ	27. MANNER OF DEATN 1 Newpel 5 Pending 2 Accident Investigation	(Month, Dey Ye		28b. TIM	E OF JURY M		URY AT RK? 'ES 2 NO	28d. DE\$	CRIBE NOW IN	JURY OCC	URED	
TTENDI TTOR: A after da		3 Suicide 8 Could not be determined	28a. PLACE DF INJ building, etc. (JRY — At ho Specify)	me, farm,	street, facto	ory, office			TION (Street as F Town, State)	nd Number	or Rural R	oute Number,
E 18 19 2	COMPLET	29a. CERTIFIER 1 CERTIFYING PNYSH	CIAN: To the best of my ki	nowledge, de	ath occurr	ed at the ti	me, data	and place, and dua	10 the caus	se(s) and man	ner as atate	nd.	
HOSPITAL FUNERAL within 72 I	OM		R: On the basis of examin										and manner as stated.
TO THE HOSPIT TO THE FUNER, be filed within 7	ш	296. SIGNATURE AND TITLE OF CERTIFIER	2					29c. LICENSE NUM	MBER		29d. DATE	SIGNED	(Month, pDay, Year)
₽ ₽ ₽ 3	10 B	Jun C 7	tuller	me	>			AF 96	00	1	•	7/2	7/95
		30. NAMELAND ADDRESS OF PERSON WH	COMPLETED CAUSE OF	DEATH (TE		/		1	60 n	1	7		2010
1	H	31. DATE FILED (Month, Day, Year)	P. REGISTRARIS S	7 U	90	yen	b	ou.	Bel	Ton	1	20.	274

SO. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Veneracion

On, Jr., 1576 M 32. REGISTRAPES SIGNATURES Julia Wandson Roydall

Dr.B.

C

o,	within
BOX 13146,	E HOSPITAL OR ATTENDING PHYSICIAN. The law remaines that the death certificate be executed within
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MECONDS, P.O.	death
D	the
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DIVISION OF VITAL	CIAN
5	PHYS
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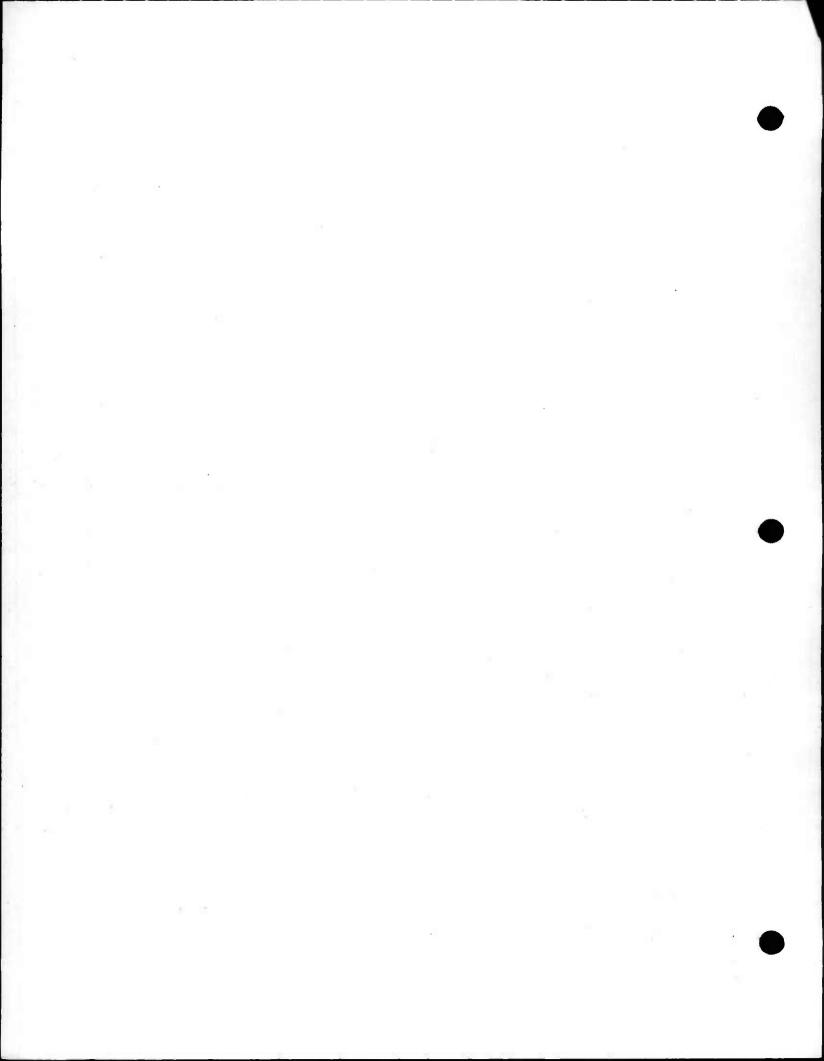
ist conditions, it to immediate UNDERLYING see or injury events eeth) LAST EFERRED TO MEDICAL To Death	ARTERIO. DUE TO (OR AS A CO	ont 3 DOA OTHER STRUCK OF INJURY M	## SF/RATO ## HEART BRA/N Inderlying cause given in ## 26. PLACE OF DEATH (C) ## 26. PLACE OF DEATH (C) ## 26. INJURY AT ## WORK? 1 YES 2 NO ctory, office	D / SEA S Y N D 1 Part I. 24a. WAS A PERFO 1 YES A Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, Steff	N AUTOPSY PRIMED? 2 NO NO NO NO NO NO NO NO NO NO NO NO NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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RITY NUMBER 5	5. SEX 8. AGE (In yr	s. lest birthday) IF UNDE		7 - 22		11:55p M
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Balto,

Merritt Blvd, Suite 22

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Opp. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR				CERTIF	CATE	OF	DEA	TH	MEN	TAL HYGIEN	t		
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	1 - STATE REGISTRAR	STATE OF MARYLA		NT OF HEALTH A		TAL HYGIENE	200		
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SE COMPLETED BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 243-22-6647 1 M 2 K 69 YRS. 90. FACILITY NAME (If not institution, give street and number)			IDER 1 YEAR FUNDER 24 HS DAYS HOURS CITY, TOWN OR LOCATION	MIN. (A	ATE OF BIRTH Worth, Day, Year) PT. 18,1	925NOR	TH CAROLI	NZ
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	1118 N. EDEN ST.			21213			U.S.A.		
	11. MARITAL STATUS 1 □ Never Merried 2 □ Narried 3 □ Wildowed 4 □ Divorced 12. WAS DECEDENT EVER IN U.S. ANMED FORCEST 1 □ YES X □ MO IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes If yes, specify Cuber, Masican, Puerto Rican, etc.) 1 YES 2 NO Specify			or No. 14. RACE — American Indian, Black, Write, etc. Specify: BLACK		
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/fisecondary (R-12) College (1-4 or 5 +) LOTH COOK			tone during most of working sed.)			TAURANT		
	UNKNOWN				BETTY PEARSON				
	190. MAILING ADDRESS (Simer and Number or Rural Route Aurebet. City or Eben. Zip Code JAMES WILLIAMS 5116 THE ALAMEDA BALTO, MD. 2							239	
	20s. METHOD OF DISPOSITION XIX Burlet 2 □ Cremation 3 □ Ren	novel from State come	PLACE AND DATE OF DIS	cel	100	DATE 20c. LOC	ATION — City or To	wn, State	1
	21. SIGNATURE OF FUNERAL SERVICE LI	Cuga	als	EM. PARK EZ NAME AND ADDRESS CALVIN B. 1412 F. F	SCR	UGGS FU	BALTO.		1
PHYSICIAN: MEDICAL CERTIFICATION	23. PART I. Enter the diseases, or complications that based the death. Do not enter the mode of dying, such as cerdiac or reepiratory errest, shock, or heert feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evente resulting in death) LAST Approximate Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death								
	PART II. Other significant condition			v			AUTOPSY 246	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF OEATH? 1 YES 2 NO	1
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	OTI	28. PLACE OF DEA	ATH (Check on	ly one)			1
B	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	Nursing Home 5 Resi	28d.	Other (Specify) DESCRIBE HOW IN. LOCATION (Street an		Route Number,	
ETEL	4 Homicide determined						City or Town, State)		
COMPLETED		ER: On the best of my knowle						s) end manner es stated.	
TO BE	29b, SIGNATURE AND TITLE OF SHIFFE	CMRGIM		29c. LICEN	G 60	3.6	≥ 07.2	(Month, Day, Year)	
T	30. NAME AND ADDRESS OF PERSON WITH STATE PILED (Month, Day, Year) 77 - 29 - 95	HO COMPLETED CAUSE OF OEA EG TO DAN 32. REGISTRAT'S SIGNA AUG O I	TH (ITEM 27) (Type, Print) TURE 1995	CHURI	CH t	TOME	Hosp 17	AL-ER	1

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Makestall programme

REGISTRAR

3. TIME OF DEATH

a. BIRTHPLACE (State or Foreign

5:07 pm

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH BETTY Jul 27 1995 JACKSON 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTN (Month, Day, Year) 247-26-5257 DAYS 1 M 2 F pko 81 05-17-14 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Saint Joseph Medical Center DIRECTOR Towson, Maryland Pages 1, 2, RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD. N/A BALTIMORE permit. FUNERAL 10a STREET AND NUMBER 10f ZIP CODE detached for use as the burtal-transit 6116 BELAIR ROAD 21206 retained by the hospital or attending physician. 5 should be detached for use as the burlal-tran 11. MARITAL STATUS WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Mexican, Puerto Ricen, atc.)
1 YES MINO Specify: BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 NO 1 Never Merried 2 Merried BY 3 🔀 Widowed 4 🗌 Divorced COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) UNK HOMEMAKER UNK 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) UNK BE UNK funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 RUTH MONROE PARK AVENUE hours after death. Page 6 may be 2 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of must 206. METHOD OF DISPOSITION

1 ☆ Burlel 2 □ Cremetion 3 □ Removal from State
4 □ Donation 8 □ Other (Specify) ____ MT • ZION CEMETERY 08-01-95 medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H PA completely filled in by the fal, cremation, or removal. 638 N. GILMOR STREET 23. PART I. Enter the diseases, or complications that caded the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one state on each line. IMMEDIATE CAUSE (Final other traumatic event, the disease or condition ASPIRATION PNEUMONIA resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): burial. CERTIFICATION and Sequentisity list conditions, OUE TO (OR AS A CONSEQUENCE OF): Hydiene prior to if any, leeding to immediate cause. Enter UNDERLYING physician OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): the attending p that initiated events resulting in deeth) LAST 6 PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. MEDICAL signed by t CORONARY ARTERY DISEASE shows any CEREBRAL VASCULAR ACCIDENT t, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: Dept. 23 certificate has the the State Dept 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Hem HOSPITAL: OTHER: 1 YES 2 NO 1 N Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 6 27. MANNER OF CEATH 28e. DATE OF INJURY this c 28b. TIME OF 28c. INJURY AT marked, 1 . Netural 5 Pending ВУ 1 YES 2 NO After death 2 Accident Investigation 3 Suicide 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 28 is 8 Could not be DIRECTOR: / COMPLETED 4 Nomicide tem 29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner ee stated. FUNERAL C Ξ HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basic of exemination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 5. H43974 1-15/4 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)
ALILGE S. HSIEH, M.D., St. Joseph Hospital, 7620 York

MD. 9c. COUNTY OF OFATH Baltimore 10d. INSIDE CITY YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. Specify: BLACK 16b. KIND OF BUSINESS/INDUSTRY BALTO. MD. 21201 20c. LOCATION - Cify or Town, State LANSDOWNE MD. Approximata Interval Between Onset and Death 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 TYES Z NO 1 TES 2 NO 28d. DESCRIBE NOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNEO (Month, Day, Year) Rd, Towson, ONMH-16 Rev 1/89



31. DATE FILED (Month, Day, Year)
AUG 0 1 1995

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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		1. DECEDENT'S NAME (First, Middle, I WILLIAM A	I	KLINE Jr.					of DEATH	y 19	93	8:57 a M	
Pin		4. SOCIAL SECURITY NUMBER 217=50=1662	1 🛣 M 2 🗆 F	8. AGE (In yrs. Ias 46	YRS.	F UNDER 1 YEA	8 HOURS	MIN.	9	OF BIRTH th, Day, Year) 20-194		Country)	ACE (State or Foreign
1, 2, 3 should	ERAL DIRECTOR	9a. FACILITY NAME (If not institution, of GREATER BALTIMO RESIDENCE OF DECEDEN	RE MEDICAL	CENTER	9		N OR LOCATI	ON OF DE	ATH			TY OF DEA	
mit. Pages			unty altimore			Keysv							Od. INSIDE CITY LIMITS? YES 2 NO
nsit per		100. STREET AND NUMBER 519 Lake Vista	Circle Ant	D	101. ZIP CODE 21030					10g. CITIZEN OF			
attending physician. se as the burial-transit permit. Pages	BY FUNER	11. MARITAL STATUS 1 Never Merried 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT	EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC O If yes, specify Cuben, Maxican, Pu					n, Puarto	C ORIGIN? (Specify Yea or No- 14. RAC			- American Indian, White, atc.
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d by the hord be detach	BE CO	17. FATHER'S NAME (First, Middle, Last William Albert								Middle, Maiden Mary W		ns	
e retained by 5 should be notified at	5	19a. INFORMANT'S NAME (Type/Print)								ber, City or Tow			W4 04070
may be		Kathleen R. Klij 20s METHOD OF DISPOSITION 1 A Burial 2 Cremation 3		20b, PLACE	AND DATE OF	DISPOSITION	(Name of		DAT	F 20c. LO	CATION C		, Md. 21030
rage 6 may if director, pa ner must b		4 Donation 5 Other (Specify)		Dulan	ey Val		em. Ga			-31-95	Ti	noniu	m, Md.
r deam. Pag ne funeral dir al. examiner		> & Starts	Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, Md. 2										
witimes nous arte deem, rage b may be retained by the hospital or preview filled in by the funeral director, page 5 should be detached for cremation, or removal. vent, the medical examiner must be notified at once.		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ee cerdiac or respiratory arreet, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel											
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sician and control to burish	ATIC	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING											
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een sign of Healt	MED	1 U YES 2 ⊠ NO DI									F DEATH?		
e has b te Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER?	L		TH YES			ERTAIN					
certificate h the State [PHYSIC	1 YES 2 NO	HOSPITAL: 1 Impatient 2 I				ome 5 🗆 Ra	sidence (
fter this cath with	ВУ Р	1 Natural 5 Pending 2 Accident Investigati	(Month, Day	Ybar)	INJURY	Υ	NJURY AT WORK? YES 2	NO ON	28d. DE:	SCRIBE HOW I	NJURY OCCU	RED	
TECTOR: After des n 28 is n	ETED	3 Suicide 6 Could not 4 Homicide detarmine	building, at	INJURY — At ho c. (Specify)	me, term, atre	et, tactory, of	fica			ATION (Street a or Town, State)	and Number o	Rural Rou	te Number,
THE POSTFIRE, ON ATTENDING CITED CANA. THE FUNERAL DIRECTORS After this confidence has be filled within 72 hours after death with the State Dept. PORTANT: If item 28 is marked, or item 23 is	COMPLI		HYSICIAN: To the best of m										nd menner as stated.
TO THE FUNERAL be filed within 72 IMPORTANT: If	TO BE C	296. SIGNATURE AND TITLE OF CERT					-	NSE NUMI				SIGNED (M	onth, Day, Year)
V	F	Michzel P. Boy		OF DEATH (ITER						Beltin	core,	MC)
0		AUG 0 1 1995	Julya allumba	S SIGNATURE									
													DHMH-16 Ray 1/89

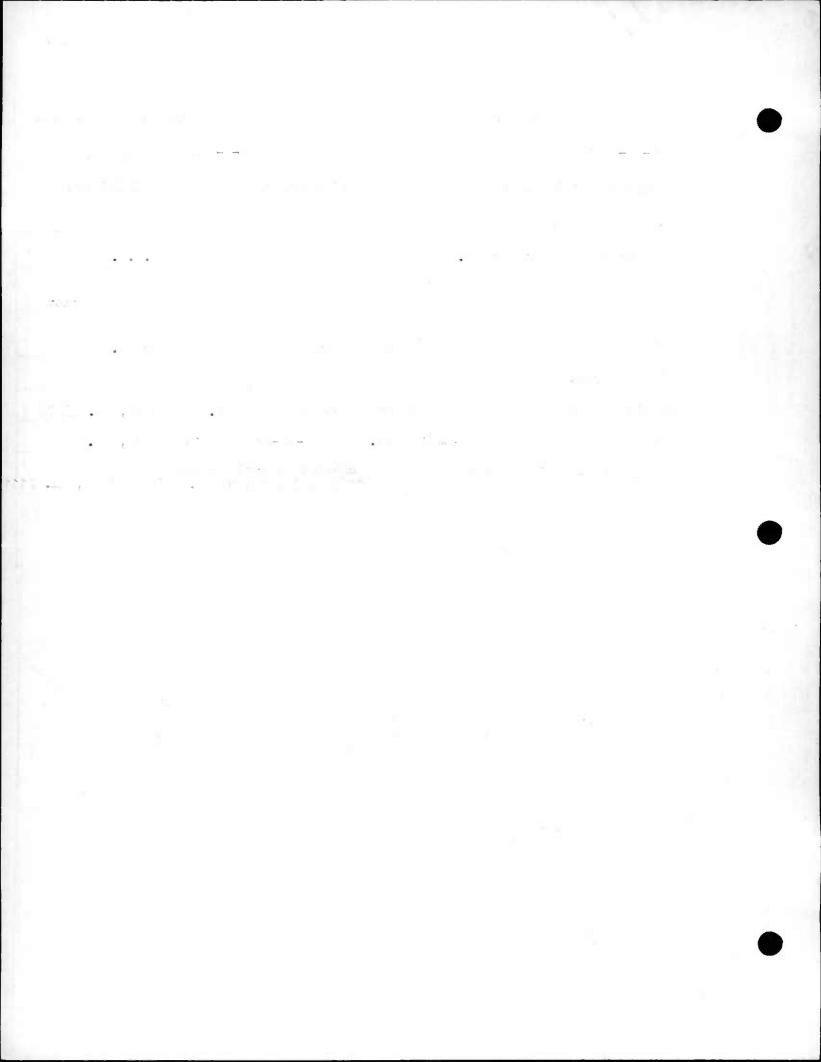
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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BALTIMORE, MARYLAND 21215-0020

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OF VI	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOX 68760	ISPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-14
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	SPITA

	_	1 - STATE REGISTRAR	STATE UF N	MARYLAND C	DEPAR						YGIENE EG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last) JOSSE	Luther	K	raft					2. DATE OF D	DAY 27	YEA 100	R	10:40p M
,		4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. Ia	_	IF UNDER		IF UNDER		7. DATE OF B	IRTH	199	RTHPLA	CE (State or Foreign
꼳		217-26-2746	1 🕅 M 2 🗆 F	81	YRS.	MONTHS	DAYS	HOURS	MIN.	3-5-I	914		untry) 1118y	lvania
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Pages	DIRECTOR	10e. STATE 10b. COUNT				Y, TOWH C					-		100	I. INSIDE CITY LIMITS?
permit. Pages 1,	2.7	Maryland Carro	TT	·		Hamp		ZIP CODE			- 1	10g. CITIZEN C		YES 2 NO
-55	FUNERAL	4606 Lower Beckle	ysville I	Rd.				210				U.S.A		COOKINI
Exhours after death. Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detached for use as the burial-transit on, or removal.	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	RMED NO	- 1	yee, spe	ENDENT O	n, Maxican	IC ORIGIN? (Sp 1, Puerto Rican	ecify Yee or , etc.)	8	ACE — lack, Wi pecify:	American Indian, hile, etc. White
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the hospital or atte detached for use once.	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 +	11/4	. Do NOT u	e Wo:		si di wonun	v		Rub	ber Co	•	
by the hor be detach at once.		17. FATHER'S NAME (First, Middle, Lest) George Kraft								ME (First, Middle	, Maiden Su	rname)		
5 should t	BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street a		nknov	NII. loute Number, Ci	tv or Town.	State. Zip Code)	
y be reta lage 5 sl be noti	5	Rosalie Fields												. 21074
death. Page 6 may be funeral director, page xaminer must be		20s. METHOO OF OISPOSITION 10 Burlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)		20b.PLACE			TION (Nai		1-19			Rock,		
ter death. Pag the funeral di yval.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Eckhardt Funeral Chapel 11605 Reisterstown Rd. Owings Mills, MD.												s. MD. 21
within- ipletely cremation		23. PART I. Enter the diseases, or shock, or heert failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	e. Seps	iaa on aach line	.				ng, auch	and Cardiac (or reapiral	ory arrest,		Approximate interval Between Onset and Death
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v requi been s t. of H shov	I: MED	DID TOBACCO USE CONT		USE OF DEA	TH YE	:s П »	JO [LINC	ERTAIN				1 [YES 2 NO
The law te has te Dep am 23	CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			E OF DEA	TH (Check o	nly one)	0.10	LIVIAN					
CIAN: Brtifica the Sta or Ite	PHYSICIAN:	1 ☐ YES 2 ☐ NO	HOSPITAL:			-		5 🗆 Re	eldence (8 ☐ Other (Spe	cify)			
DING PHYSI After this ci death with 1 \$ marked,	ву Рн	27. MANNED OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. OATE OF (Month, Da	ay, Yeer)		M		RK7 ES 2		28d. OEŞCRIB	E HOW INJU	JRY OCCURED		
OR ATTENDING PORTER OF THE POURS after death item 28 is mar	ETED	3 Suicide 6 Could not be 4 Homicide datermined	28a. PLACE Of building,	F INJURY — AI ho etc. (Specify)	ome, lerm, :	street, lacto	ery, affice	1		261. LOCATION City or Tow		Number or Run	el Route	Number,
E 45 =	COMPL	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE											e(s) enc	I manner ea stated.
TO THE HOSPI TO THE FUNEF De filed within	8	29b. SIGNATURE AND TITLE OF CERTIFIED	0					DZ.	NSE NUM	BER	2	9d. DATE SIGN	EO (Moi	nth, Day, Year)
3	5	30. NAME AND AODRESS OF PERSON WH	^	SE OF DEATH (ITE		Print)		247	ı			•		
		AUG 0 1 1995	33 RECHSTRA	R'S AIGNATURE										

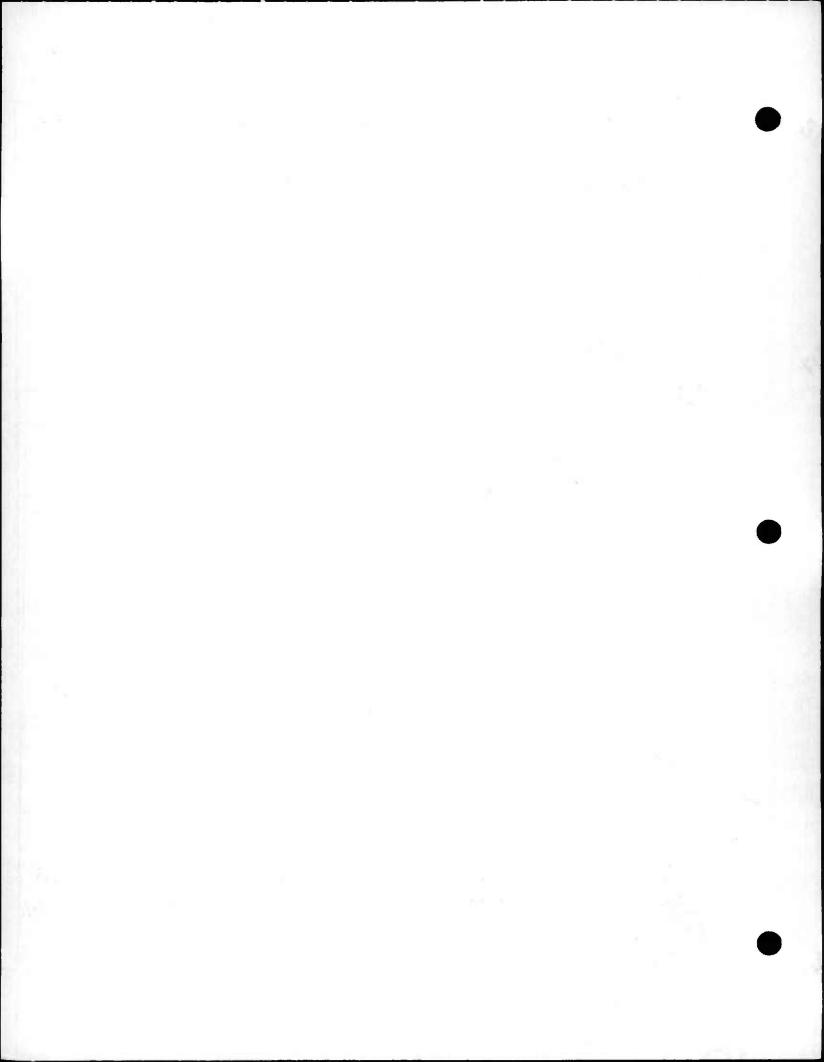


		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEP CERT	ARTMENT OF I	HEALTH AND	MENTAL HYGI REG.		
		1. DECEDENT'S NAME (First, Middle, Last) GORDON 4. SOCIAL SECURITY NUMBER		W . (In yrs. lest birthd	KEII		2. DATE OF DEATH	200 15 1	3. TIME OF DEATH
pio		212 09 9751	1 🔀 M 2 🗆 F 🛛 8	31 YRS	S. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yeal NOV • 5,	7)	s. BIRTHPLACE (State or Foreign Country) Maryland
2. 3 should	CTOR	98. FACILITY NAME (If not institution, give NORTH ARUND) RESIDENCE OF DECEDENT	in the second	+L_	G-LEN	OR LOCATION OF D	ME	9c. COUN	ARUNDEL
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rzrz U	IPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 12th	JCATION e completed) College (1-4 or 5+)	(Give kind life. Do NO	T'S USUAL OCCUPATION of work done during month of use retired.) 1esman	ON ost of working		BUSINESS/INDU	STRY
by the pe de at on		17. FATHER'S NAME (First, Middle, Last)	Charles Kei	.1			AME (First, Middle, Mai		
ay be retained page 5 should be notified		19a. INFORMANT'S NAME (Type/Print) Eileen Reavey			NG ADDRESS (Street a				code) land 21144
e 6 m.		20e. METHOD OF DISPOSITION 1 St Burlel 2 Cremation 3 Ren 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNER CRIVICAL	noval from State Cent	netery, crematory	<u>te Veterar</u>	s Cem.	7/31 C		ille, Maryland
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within 24 hours at poletely filled in by cremation, or remorent, the medica		23. PART I. Enter the diseases, pr shock, or heert fellure. IMMEDIATE CAUSE (Finel disease pr condition resulting in death)	complications that caused Liet only one cause on a DUE TO (OR AS A	STATI	no not enter the mo	de of dying, suc	ARCING	epiratory srre	et, Approximete Interval Between Onset and Death
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w requires that the death is been signed by the atter pr. of Health and Mental 3 shows any injury, o	MEDICAL	PART II. Other significent condition ON GES TIVE CO FON AM	HEARI	RY F	DISEA	g ceuse given in	PER	AN AUTOPSY FORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
The late has ate De ate De em 2	AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?			YES NO C EATH (Check only one)	UNCERTAI	N 🔲		
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TTENDING TOR: After after death	<u>a</u>	2 Accident Investigation 3 Suicide a Could not be datarmined	28s. PLACE OF INJURY building, etc. (Spec	— At home, farm		YES 2 NO	28t, LOCATION (Str. City or Town, St	eet and Number o	r Rural Route Number,
로 보 Z ==	MPLE		ICIAN: To the best of my know						1. cause(a) end manner es atated.
TO THE HOSPI TO THE FUNER be filed within		29b. SIGNATURE AND TITLE OF CERTIFIE		tours=	DEVER	29c. LICENSE NUI			SIGNED (Month, Day, Year)
7+1	10	30. NAME AND ADDRESS OF PERSON WE ANDREW OKETAAN	O COMPLETED CAUSE OF DE	30\	HOSPITAL	- DRIVI	E. CHEN	BURN	E Ms. 21061

AJOKU OKETZANTI.

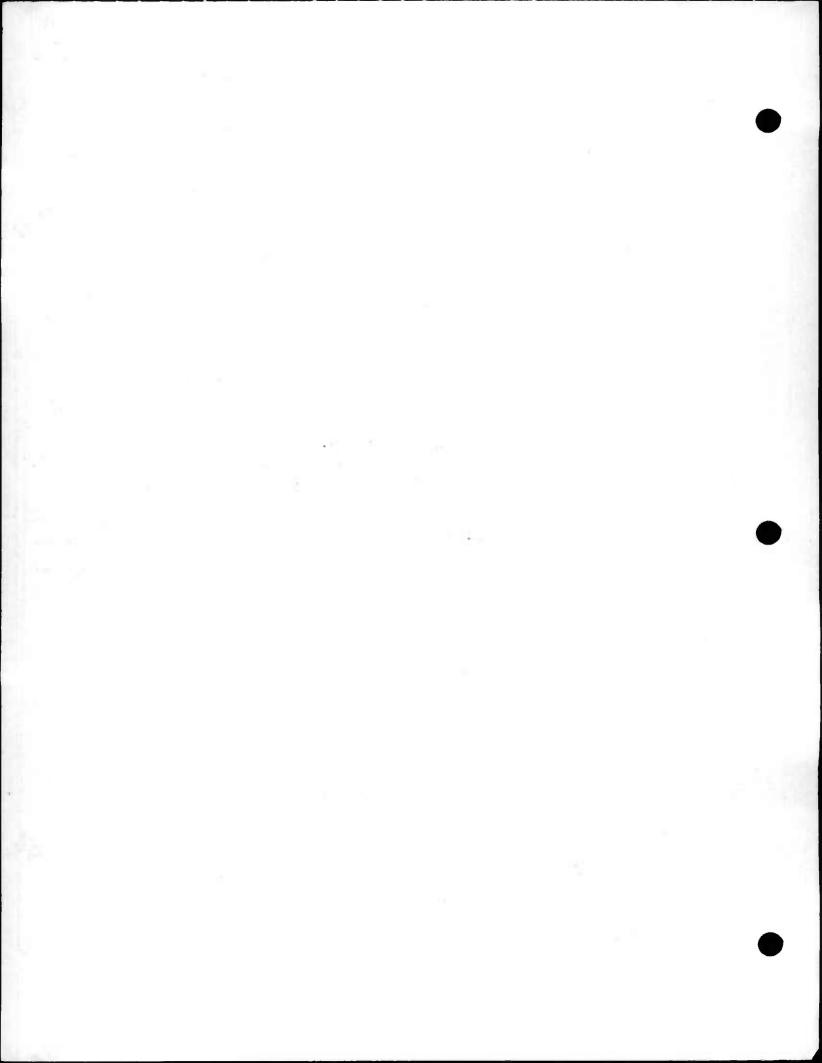
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		1 - STATE REGISTRAR 1. OECEDENT'S NAME (First, Middle, Last)		CE				DEAT		REG. NO.	D.		3. TIME OF DEATH
		Johr	0	ht						July 30	DAY 1	995	1:40 p
		4. SOCIAL SECURITY NUMBER 302-34-8373	5. SEX 6. /	NGE (In yrs. lest		IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		6. BIRTHE Country	PLACE (State or Foreign
should		9e. FACILITY NAME (If not institution, give			YRS.	ab 0077	TOWN C	R LOCATIO		Jan. 26, 1			ndiana
2,3	СТОВ	3602 Third Stre				96. CITY		timo		ATH		I/A	АТН
Pages 1,	ш	10e. STATE 10b. COUNT			10c. CIT	Y, TOWN							10d. INSIDE CITY
#: - 28	BI	Maryland N	'A				В	altir	nore				LIMITS? 1 YES 2 NO
n. ansit permit.	FUNERAL	3602 Third Stree	et				101	. ZIP CODE	2122	5	10g. CIT	USA	HAT COUNTRY?
il or attending physician. for use as the burial-transit	BY FUR	11. MARITAL STATUS 1 Never Married 2 Merried 3 X Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1X 1 IF YES, GIVE WAR O KOYEAN	YES 2 N	0		If yes, sp	ecify Cubar		C ORIGIN? (Specify Ye , Puerlo Ricen, etc.)	e or No—	Specify	
as	ED	15. DECEDENT'S EDU	16a, DE0	CEDENT'S	USUAL O	CCUPATIO	ON .		16b. KIND OF BU	ICINECC/IN		hite	
	ш	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			re kind of	work done se retired.)	during mo	st of working	g	IOU. KIND OF BU	SINESSAM	DUSTRI	
pe spit	COMPL					r				Railroa	ad		
tonce,	8	17. FATHER'S NAME (First, Middle, Last)							NE (First, Middle, Maider				
should be tiffied at	8	WILLIAM IN 190. INFORMANT'S NAME (Type/Print)	nomas Knigh		MAILING	ADDRESS	/Chand			Emma Illy oute Number, City or Tov			<u>_</u>
be re	임	David Joseph Kni	ght			Kesw.				timore, M			
je 6 may irector, pi must		20e. METHOD OF OISPOSITION 1 Burlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)		20b. PLACE A cemetery, crer METIO	nd date	ator	y, I	nc.		31/95 Ba	altim	ore,	MD
hours after death. Page 6 may be ed in by the funeral director, page or removal. medical examiner must be		22. NAME AND ADDRESS OF FACILITY Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228											
d in by the or removal medical		23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such ea cardiec or respiratory arrest,											
filled in on, or re		Interval Batween											
age .		disease or condition											X Munth
pa in in		DUE TO (OR AS A CONSEQUENCE OF):										/ monne	
and o bur	CERTIFICATION	Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF):									X YP		
physician pe prior to	CAT	If any, leading to immediate cause. Enter UNDERLYING											
certificate ding physi lygiene pr	THE	CAUSE (Disease or Injury that initiated events resulting in destinal LAST											
E 8 - 6	띩	resulting In death) LAST										-	
	- 11	PART ii. Other algnificent condition	na contributing to deel	th but not re	aulting	in the un	derlying	ceuse g	iven in F	Part I. 24a. WAS AN			WERE AUTOPSY FINDINGS
는 요는 일	DICAL									1 YES :			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
law requires that as been signed lept, of Health a 23 shows any	ME									_	/		YES 2 NO
bas has	SICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE			TH (Check		UNC	ERTAIN				
두 일 등 등	S	EXAMINER?	HOSPITAL:			OTHER	1:	-V					
SICIA certif h the	PHY	27. MANNER OF DEATH	28a. DATE OF INJU	RY	28b. TIM	E OF	28c. INJU	JRY AT		Other (Specify) 28d. DESCRIBE HOW	INJURY OC	CURED	
NG PHYS ter this auth with marked	ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye	er)	INJ	JURY M	1 🔲 Y	RK? ES 2 🗌					
CTDR: A after de 28 Is	<u>a</u>	3 Suicide 6 Could not be determined	26e. PLACE OF INJ building, etc. (URY — At hon Specify)	ne, farm, :	street, fact	ory, office	1		281. LOCATION (Street City or Town, State)	and Number	r or Rural Ro	ute Number,
OR DIR	PLET	290. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my k	nowledge, das	th occurr	ed at the ti	me, date	end place.	end due 1	0 the cause(s) and me	mner ae eta	ted	
Z 7 2 =	COMP		R: On the beele of examin										end menner ee stated.
HE HO HE FUI BIG WITH	w II	296. SIGNATURE AND TITLE OF CERTIFIE	1/	7			T	29c. LICE	NSE NUME	BER	29d. DAT	E SIGNED (Month, Day, Year)
TO THE HOSPIT TO THE FUNERA be filed within ?	10 B	1/VM/ L	Mu CA	/				1)0	7:	259	▶ J	uly 3	1, 1995
	-	John J. Mann, M.					20	0, Li	ıther	cville, M	210	93	
		31. DATE FILED (Month, Day, Year)	32. BEGISTRAR'S S									_	
		AUG 0 1 1995	Jalin Dace	Ser las	Like								



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 2/215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. In hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTA			MENTAL HYGIEN				
Į.	1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF OEATH		3. TIME OF DEATH		
	Sophie Elizabeth I					July a	36 9	5 220 1		
1				UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)		
	9a. FACILITY NAME (If not institution, give stree	,,,		CITY TOWN C	PR LOCATION OF D	2-28-16		ennsylvania		
E .	Union Memorial Hose			2. 0111, 101111	T LOURING OF D	LAIN	Ceci			
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		I ii anii				1 Cect			
DIRECTOR	Maryland Cecil			OWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?		
	10e. STREET AND NUMBER		Elkt		ZIP CODE		1 YES 2 NO			
E	150 Iron Hill Road				21921			.A.		
FUNERAL		2. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Ye	_	. RACE — American Indian, Black, White, atc.		
Æ	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DAT	res X		2 NO Specif			specify: White		
8	15. DECEDENT'S EDUCAT	TION	16a. DECEDENT'S US	UAL OCCUPATION	DN .	16b. KIND OF BU	SINESS/INDUS			
COMPLETED	(Specify only highest grade con Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of work life. Do NOT use re	done during mo tired.)	st of working					
MP										
	17. FATHER'S NAME (First, Middle, Last) John Huminski					ME (First, Middle, Maiden	,			
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street a		<u>minski Kar</u> Route Number, City or Tov		(VI)		
2	Joan Delawaski					ilmington,				
	20a. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Remove		PLACE AND DATE OF D	ISPOSITION (Na				y or Town, Stata		
	4 Donation 5 Other (Specify)	-21								
	21. SIGNATURE OF FUNERAL SERVICE LICEN	see Ronald Was	de, ver.	State	Anatomy	Board-655	W. Ba	ltimore Street		
	Janua /	/accom		Rm.BO	26-Balti	more, Mary	land	21201-1559		
	23. PART i. Enter the diseases, or con shock, or heart fallure. Lie	nplications that caused it only one cause on sec	the deeth. Do not ch line.	enter the mo	de of dying, suc	h es cerdiec or reep	iratory srres	interval Batween		
	IMMEDIATE CAUSE (Final disesse or condition	congestine	Hout Co.	.0.				Onset and Death		
	resulting in death) a	DUE TO (OR AS A (CONSEQUENCE OF):							
Z	Sequentially list conditions, b	gestroui	wheel e	A-V nue	Sud'h	un!				
CERTIFICATION	if sny, lesding to immediate cause, Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF): LOPD. Direction Melletus DUE TO (OR AS A CONSEQUENCE OF): Bled. My occed Fufaction								
밀	CAUSE (Disease or Injury that initisted events	DUE TO (OR AS A C	ils Mi							
ᇤ	reaulting in deeth) LAST	old, m	yourd .	Fuface	hou					
AL C	PART II. Other eignificent conditions of			-		Part I. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS		
101						PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDI							74	OF DEATH?		
	DID TOBACCO USE CONTRIE				UNCERTAI	N 🗆				
PHYSICIAN:		IQSPITAL:		THER:						
H	1 VES 2 NO 1 27. MANNER OF DEATH	26a. DATE OF INJURY	28b. TIME O	F 26c INJ		6 Other (Specily) 28d. DESCRIBE HOW	IN ILIEN OCCUE	nen.		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WO	RK? ES 2 NO	233. DEGOTIOE NOW	MOONT OCCOR	neb		
ED B	3 Suicide 6 Could not be	28a. PLACE OF INJURY building, atc. (Specif)	- Al home, lerm, atres	nt, lectory, office	,	281. LOCATION (Street City or Town, State)		Rurel Route Number,		
	4 Homicide determined					City or lown, Grand,				
COMPLET		N: To the beat of my knowled								
00	2 MEDICAL EXAMINER: (On the besis of examination	and/or investigation, is	n my opinion, de			nd due to the c	euse(a) and mennar as stated.		
BH	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI		29d. DATE S	IGNED (Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type. Prin	nt)	DO 48.	23				
	Jui chih	HSU, M	D 2		west n	voice sit.	FICTOR	Md 21921		
	31. DATE FILED (MODITY, Day, Year) 1995	32, REGISTRAR'S SIGNAT	Rodall !			T	-			

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY YEAR ILSE JULY 29, 1995 PRAGER KESSLER 21:48 P 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Month, Day, Year)
JAN. 26, 1926 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 6. AGE (In yrs. last birthday B. BIRTHPLACE (State or Foreign 213-28-1664 DAYS HOURS 1 M 2 DF 69 GERMANY Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 7104 BOXFORD RD. N/A BALTIMORE RESIDENCE OF DECEDENT 10s. STATE 10h. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/A BALTIMORE 1 XYES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7104 BOXFORD ROAD humeral director, page 5 should be detached for use as the burial-transit 21215 USA Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indien, Black, White, stc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried If yes, specify Cubs
1 ☐ YES 2 X NO BY 3√ Widowed 4 Divorced Specify WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 SEAMSTRESS CLOTHING once. 17. FATHER'S NAME (First, Middle, Last) GEORGE 18. MOTHER'S NAME (First, Middle, Maiden Surname)
JENNIE PRAGER **FUCHS** notified at BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 9521 WINDBEAT WAY COLUMBIA, MD 21046 MRS. MIMI ROSENDORF pe 204 METHOD OF DISPOSITION
1 XBuriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stats must HEBREW FRIENDSHIP 7-31-1995 4 Donation 5 Other (Specify) BALTIMORE, MD examiner 21. SIGNATURE OF BUNERAL SERVICE L 22. NAME AND ADDRESS OF FACILITY hours after death. SOL LEVINSON & BROS., INC. filled in by the higher from our removal. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 medical 23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. intarvai Between **IMMEDIATE CAUSE (Final** Onset and Daath and completely fille burial, cremation. the disease Dr condition Hypertensive Arteriosclerotic Cardiovascular Disease resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury the attending phy Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? апу 1 - YES 2 X NO Shows 1 YES 2 XNO t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has by Dept. PHYSICIAN: WE 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) The h the State L EXAMINER? HOSPITAL: TX YES 2 - ND HOSPITAL OR ATTENDING PHYSICIAN: 1 Inputient 2 ER/Outputient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked, 5 Pending 1 YES 2 NO BΥ After death 2 Accident Investigation 28s. PLACE OF INJURY — At homs, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide DIRECTOR: A hours after d item 28 is 6 Could not be .00 COMPLETED 4 Homicide determined 29s. CERTIFIER 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placs, and due to the cause(s) and menner as stated. FUNERAL | = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 💢 MEDICAL EXAMINER: On this basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Day, Year) Wrught MI) OCME JULY 30,1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donald G. Wright M.D. 111 Penn Street, Baltimore, Maryland 21201 31. DATE PILED (Month, Day, Year) 2. REGISTRAR'S SIGNATURE 1995

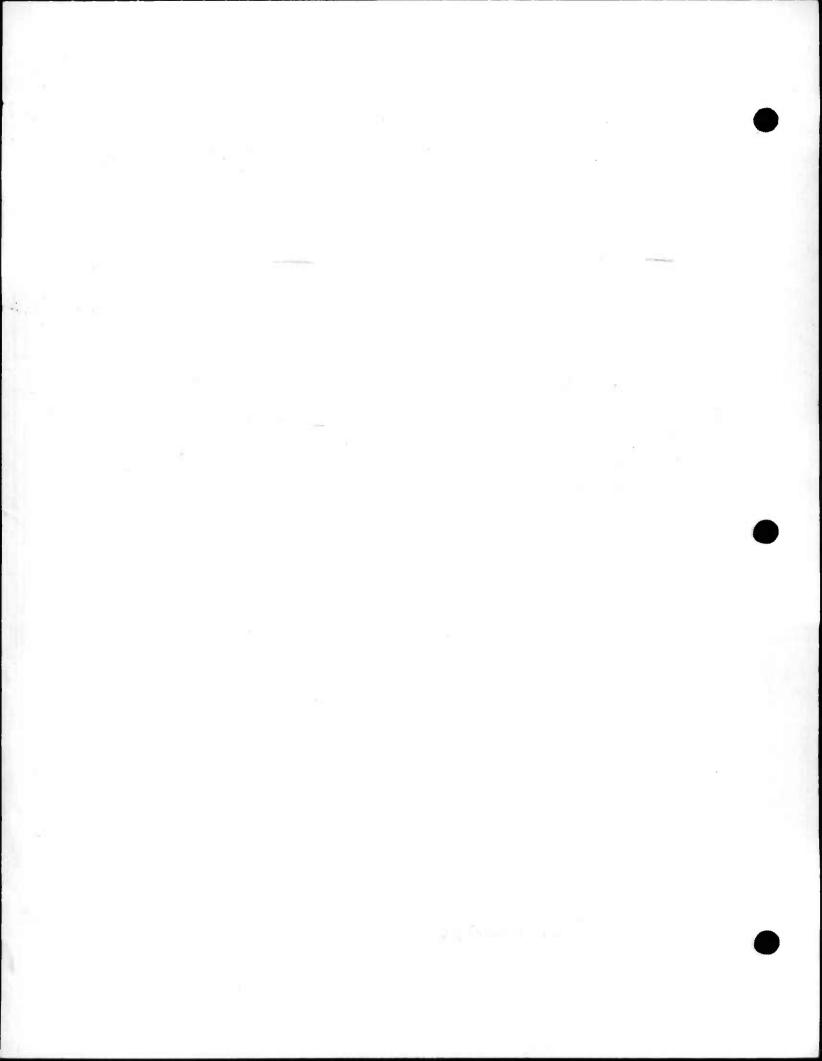
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME DATE OF DEATH TIME OF DEATH 12:55 A 4. SOCIAL SECURITY NUMBER 5. SE T. DATE OF SHITH (Month, Dgy, Year, Apr. 14 IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 M 2 VF 216-20-0140 71 Apr. 1924 MARYL AND funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c COUNTY OF DEATH DIRECTOR DEATON NURSING CENTER BALTIMORE CITY N/A10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/A Y YES 2 NO BALTIMORE CITY FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF 2504 MOSHER STREET 21217 21216 5 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS OECEDENT EVER IN U.S. ARMED WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-it yes, specify Cuben, Maxicen, Puerto Rican, atc.)
 \(\subseteq \text{YES XXNO} \)
 Specify: 14. RACE --- American Indian, Black, White, etc. FORCES? 1 YES 2 NO 1 Never Married 2 Married В Specify: 3 Widowed 4 Divorced BLACK 18e. DECEDENT'S USUAL OCCUPATION BE COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade HOUSEWIFE LINKNOWN 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) notified at JAMES F. POWELI VERDELLA SMITH 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 2504 MOSHER STREET, JOHN KIRKLAND RALTIMORE MARYLAND 21217 pe 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must OATE GARRISON FOREST VETERANS 8/2 OWINGS MILLS MARYL AND TI. BIGNADURE OF examiner FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WILLIAM C. BROWN COMMUNITY F/H the 1206 W. NORTH AVENUE medical 23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, attending physician and completely filled in by mal Hygiene prior to burial, cremation, or remo Approximate shock, or heart feilure. List only one ceuse on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death event, the disease or condition Hemorrhage introcure bral Months reaulting in death) executed with DUE TO (OR AS A CONSEQUENCE OF): Hypertersion traumatic CERTIFICATION ears Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediata cause. Enter UNDERLYING the death certificate be CAUSE (Disease or injury other signed by the attending phy Health and Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF 0EATH? Stroke PERFORMED? shows any 1 YES 2 TO NO 1 YES 2 NO t. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO VINCERTAIN PHYSICIAN: has b Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The certificate HOSPITAL: OTHER: 1 YES 2 PNO 1 Dinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED with marked. this 1 Natural 5 Pending BY 1 YES 2 NO death Investigation After 2 Accident 3 Sulcide 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .09 0 Could not be DIRECTOR: after 4 Homicide 28 determined COMPLET hours 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end manner ee stated. TO THE HOSPITAL OF THE FUNERAL DE BE filed within 72 h 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end menner ee stated. E AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) B D3867 128/95 MD 2 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOE L MESHULAM 5 HANOVER 1147 ST BALT MD 21230 REGISTRAR'S SIGNATURE 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at nace.	
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31. DATE FILED (MORTH, Day, Year) AUG 0 1 1995

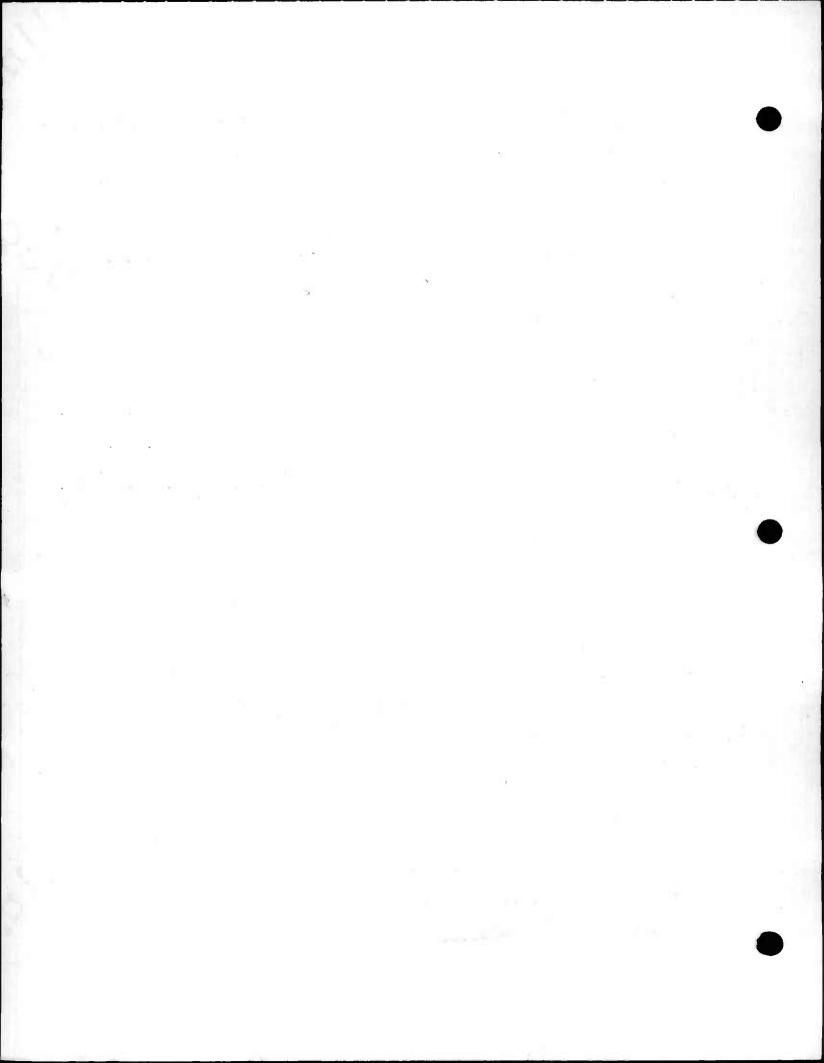
										35	23080	
	FOR STATE REGISTRAR	STATE OF	MARYLAND /	DEPAR	TMENT O	F HEALTH	AND	MENTAL HYGIE				
	1. DECEDENT'S NAME (First, Middle, I	Lest)	Ci	EKIIF	ICATE (JF DEA	IH_	REG. N	0.		. =	
	Mabel 7	7.	La	uer				JULY 3	DAY	YEAR	3. TIME OF DEATH 5:45 P M	
	4. SOCIAL SECURITY NUMBER	5. SEX	5. SEX 6. AGE (In yrs. last birthday) IF UNDE				R 24 HRS.	7. DATE OF BIRTH		995	PLACE (State or Foreign	
ł	184-50-4032	1 🗆 M 2 💢 F	96	YRS.	MONTHS DA	YS HOURS	MIN.	(Month, Day, Year) 2-15-18	399	Country	YLAND	
	9a. FACILITY NAME (If not institution,	give street and number)	1		9b. CITY, TO	WN OR LOCAT	ON OF DE					
O. H	SUBURBAN HOS				ROC	KVILI	E		MOI	NTGON	MERY	
[RESIDENCE OF DECEDENT			1 40 017	Y. TOWN OR L				1			
DIRECTOR		TGOMERY		10c. C11	POTO						10d. INSIDE CITY LIMITS?	
	10a. STREET AND NUMBER	VI COMBINI			1010	10f. ZIP COD	F		I 10= 01		1 YES 2 NO	
FUNERAL	8521 HORSESH	OE LANE				208			_	S.A.		
3	11. MARITAL STATUS	12. WAS DECEDE	NT EVER IN U.S. AR	MEO	13. WAS			VIC ORIGIN? (Specify)			- American Indian,	
	1 Never Married 2 Married		1 YES 2 KN	10	I1 yes	yes 2 NO	ın, Mexica	n, Puarto Rican, etc.)		Black, Specify	, White, etc.	
Э ВУ	3 Widowed 4 Divorced		35,000							Gpecin	WHITE	
1 11	15. DECEDENT'S (Specify only highest	EDUCATION grade completed)	16a. DE	CEDENT'S	USUAL OCCUI work done during se retired.)	ATION most of worki	ng	18b. KIND OF B	USINESS/IN	DUSTRY		
1 "	Elementary/Secondary (0-12) 1 2	College (1-4 or 5	+)		WIFE			HOMEN		-		
COMPLETED	17. FATHER'S NAME (First, Middle, Last	7)	ne	JUSE	WILE	40.000		HOMEN				
	GEORGE W. BI	•				- 1		ME (First, Middle, Maide A MAE EF	,			
3 8	19a. INFORMANT'S NAME (Type/Print)		198	MAILING	AODRESS (Str			Route Number, City or To		in Code)		
	SUZANNE O. MI	LLER						NE HERNI			22071.	
must be	20a. METHOD OF DISPOSITION 1 Buriat 2 Crematton 3		20b. PLACE	NDDATE	OF DISPOSITION	(Name of				- City or Tow		
	4 Donation 5 Other (Specify)		_ WOODI	ÄWN	CEME	TERY		8/95 BA	LTO.	,MD.		
CYGIIII	21. SIGNATURE OF FUNERAL SERVICE					E AND ADDRE			CON	10.00		
	P.H. Ku	tte						ENKINS 8 RD. BALT				
	23. PART I. Enter the diseases,	or complications th	at causad tha da	ath. Do r	ot antar tha	moda of dy	ing, suci	h as cardiac or res	piratory a	rrest.	Approximats	
	shock, or hasrt falls IMMEDIATE CAUSE (Final	ure. List only one ca	use on each line.								interval Between Onset and Daath	
	disease or condition resulting in death)	Pu	dicol	an	12	00011	onin				Onset and Dastin	
	resulting in destiny	OUE TO	OR AS A CONSEC	UENCE OF	7), C	J VCCCC	1					
Z	Sequentially list conditions,	To no	weller re	e De	eldell	t de	also	ches 1	UPP	iho		
CERTIFICATION	if any, lasding to immediata	DUE TO	(OR AS A CONSEC	URNCE OF	7:	ti.	- 1		/			
	Cause. Enter UNDERLYING CAUSE (Disease or injury	c. OHE TO	OR AS A CONSE	0/200	micell	lee f	1011.	Manie	des	RUS)	
E	that initiated events resulting in death) LAST	002 10	(OH AS A CONSEC	DENCE OF	·):	4		/				
		d										
AL AL	PART II. Other significant cond	itions contributing to	dasth but not re	suiting i	n tha undari	ying cause	given in		N AUTOPSY		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
MEDICAL								1 YES	- 4		COMPLETION OF CAUSE OF DEATH?	
¥								_ 1	•		1 TYES 2 NO	
PHYSICIAN:	DID TOBACCO USE CO		USE OF DEAT	TH YE	S 🗆 NO	□ UNC	ERTAIN	1 DEL				
2	25. WAS CASE REFERRED TO MEDICA EXAMINER?	HQSPITAL:	26. PLAC	E OF DEAT	H (Check only o	nne)						
. ×	1 TYES 2 NO	1 Inpatient 2	ER/Outpetient 3		4 - Nursing I		aldence	6 Other (Specify)				
	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE Of (Month, I	Pay, Year)	28b. TIMI INJ	URY	INJURY AT WORK?	- 15	28d. DESCRIBE HOW	INJURY OC	CURED		
B	2 Accident Investigat		F INJURY At hor	no dosm s		YES 2	NO					
	3 Suicida 6 Could not 4 Homicide detarmine	Duliding.	etc. (Specify)	na, rarm, a	treet, tectory, c	ITICA		City or Town, State	end Numbe e)	r or Rural Ro	ute Number,	
LET	29a. CERTIFIER		an etchia ex						_			
COMP	(Check only	HYSICIAN: To the best of										
	29b. SIGNATURE AND LITLE OF CERT	MINER: On the basis of a		.veetiget10	, iii iiiy opinio				,			
H	250. SIGNALUNE AND PITE OF CERT	18 m/1	015	Y		29c. LICE	NSE NUM	IBER	29d. DA	E SIGNED	(Month, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CALL	SE OF DEATH /ITEM	27) (Tona	Print)	10	<->/	10	7	150	/ -)	
1			title	1 1 1 1 po.								

BAKSHI, M.D., SUBURBAN HOSPITAL,

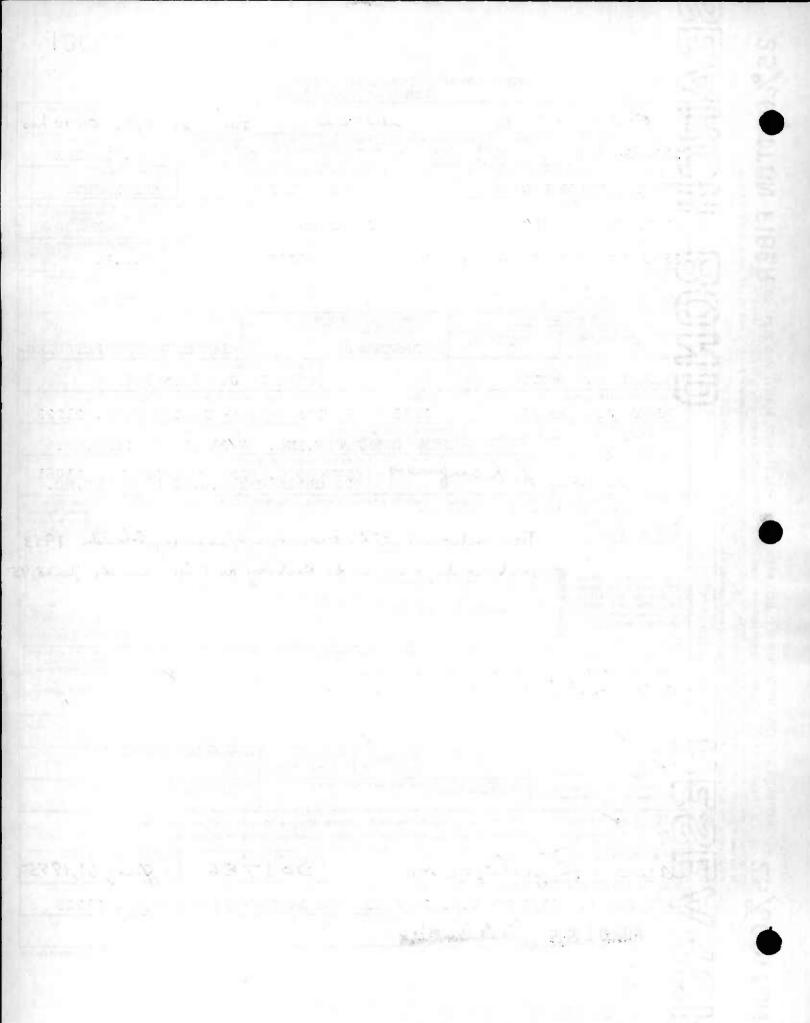
32. REGISTRAR'S SIGNATURE

MARYLAND

ROCKVILLE,



	1. DECEDENT'S NAME (First, Middle, L		CERTIF		,	2. DATE OF DEAT		3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	Comp. 1	. AGE (In yrs. last birthday)	NTOX		2017	31 19	95 0640		
	213-03-6249 9a. FACILITY NAME (If not institution, g	1 □ M 2X F	89 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Month, Day, Ye 04 06	°′ 06 W	BIRTNPLACE (State or Fore Country) VIRGINIA		
стоя	SUMMIT NURSIN	NG HOME			OR LOCATION OF D			Y OF DEATH TIMORE		
DIREC	10a. STATE 10b. CO		10c. CIT	Y, TOWN OR LOCATE				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
ERAL	100. STREET AND NUMBER 3300 BENSON A	AVENUE-APT	:#107	101	1. ZIP CODE 21227			N OF WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	ver Married 2 Married FORCES? 1 YES 2 NO			CENDENT OF HISPA pecify Cuban, Maxic 2 NO Speci	C.)				
ETED	15. DECEDENT'S (Specify only highest of	grade completed)	USUAL OCCUPATION Work done during mose retired.)	ON ost of working	16b. KIND 0	F BUSINESS/INDUS	TRY			
APLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	SEAMST			CLOT	HING MA	NUFACTURI		
BE COMPL	17. FATHER'S NAME (First, Middle, Last ISAAC M. I	0 BOYER		MARTHA	J.	alden Surname) REYNOLD	S			
TO E	19a. INFORMANT'S NAME (Type/Print) MARY J. KE	ENDALL			and Number or Rural			ode) ,MD. 2122		
	20a. METHOD OF DISPOSITION 1 Burlal 2 M Cremation 3		20b. PLACE AND DATE	OF DISPOSITION (NA	ama of		e. LOCATION — CIT			
	4 Donation 5 Other (Specify)	- 2-	METRO CR	- V			CATONSV	ILLE, MD.		
	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE!	Λ	1 22. NAME A	22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY.S.W.GLEN BURNIE, MD.					
		of complications that come. List only one cause	eused the deeth. Do no on each line.	RAYM 426	OND C. CRAIN H	FINK FINK FINK FINK		t, Approxime		
NOI	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions,	We. List only one cause	on each line.	RAYM 426	OND C CRAIN H	FINK FINK FINK FINK FINK FINK FINK FINK	raepiratory arrea	Approxime Interval Be Onset and		
ERTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. Travel DUE TO (O) oue TO (O)	on each line.	RAYM 426 not enter the mo	OND C CRAIN H	FINK FINK FINK FINK FINK FINK FINK FINK	raepiratory arrea	Approximet Interval Bet Onset and		
AL CERTIFICAT	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	a. Transport Due To (o) b. Modal oue To (o) c. Due To (o) d.	R AS A CONSEQUENCE OF	RAYM 426 not enter the model of the care first f	OND C CRAIN H ode of dying, suc	FINK FINK FINK FINK FINK FINK FINK FINK	raepiratory arrea	Approximet Interval Bet Onset and Calle, 19		
MEDICAL CERTIFICAT	shock, or heert falls IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	a. Transport Due To (o) b. Modal oue To (o) c. Due To (o) d.	R AS A CONSEQUENCE OF	RAYM 426 not enter the model of the care first f	OND C CRAIN H ode of dying, suc	FINK FINK FINK FINK FINK FINK FINK FINK	Lynness AN AUTOPSY REORMED?	24b. WERE AUTOPSY FIN AMAILABLE PRIOR TO COMPLETION DF CA OF GEATH? 1 YES 2 NO		
MEDICAL CERTIFICAT	ahock, or heer falls IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificant cond Why of the conditions of	a. Transport one cause a. Transport of the transport of t	R AS A CONSEQUENCE OF	RAYM 426 not enter the mo	OND C CRAIN Folde of dying, such	FINK FINK FINK FINK FINK FINK FINK FINK	Dynales	24b. WERE AUTOPSY FININAMAILABLE PRIOR TO COMPLETION DE CA		
PHYSICIAN: MEDICAL CERTIFICAT	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICAEXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending	a. Due TO (O) b. Mulanting to de AL HOSPITAL: 1 Inpetient 2 E 28a. DATE OF IN (Month, Day).	RAS A CONSEQUENCE OF	RAYM 426 not enter the mo coll corr F): in the underlyin 26. Pi OTHER: 4 (Pituraing Norn ille OF 28c. Ni. WC	OND C CRAIN Hode of dying, such	Part I. 24a. W Peck only one) 6 Other (Specific	Dynales	24b. WERE AUTOPSY FIN AMAILABLE PRIOR TO COMPLETION DE CA OF GEATH? 1 YES 2 NO		
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ETED BY PHYSICIAN: MEDICAL CERTIFICAT	ahock, or heer falls IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine 29a. CERTIFIER (Check only One) 2 MEDICAL EXA	a. Due TO (O) b. Due TO (O) c. Due TO (O) d. Due To (O) d.	R AS A CONSEQUENCE OF R AS A CONSEQUENCE OF	RAYM 426 not enter the mo CL Car F): In the underlyin 26. Pi OTHER: 4 Phursing Non IE OF VIENT M 1 street, factory, office ed at the lime, date	COND C CRAIN F ode of dying, such controls g cause given in LACE OF OEATH (C) ne 5 Raeldence JURY AT ORK? YES 2 NO	Part I. 24a. W Per I V Peck only one) 6 Other (Specific City or Yown, to to the cause(a) and	Degraph SAN AUTOPSY REORMED? ES 2 PNO Tirrest and Number or State) d menner as stated.	24b. WERE AUTOPSY FIN AMAILABLE PRIOR TO COMPLETION DE CAMPLETION DE CAM		
ED BY PHYSICIAN: MEDICAL CERTIFICAT	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending Investigat 3 Suicide 6 Could not determine (Check only One) 2 MEDICAL EXAMINERS.	B. CALL DUE TO (O) b. MALL DUE TO (O) c. DUE TO (O) d. DUE TO (R AS A CONSEQUENCE OF AS A	RAYM 426 not enter the mo CL CDT F): In the underlyin 26. Pi OTHER: 4 Phursing Non IE OF JURY M I street, fectory, office ed at the lime, data on, in my opinion, c	COND C CRAIN F ode of dying, such controls g cause given in LACE OF OEATH (C) ne 5 Raeldence JURY AT ORK? YES 2 NO	Part I. 24a. We heat and place to the cause(a) and time, data and place.	Legral SAN AUTOPSY REFORMED? ES 2 PNO DIVIDITION INJURY OCCUI Street and Number or State) d manner as stated. se, and due to the co	24b. WERE AUTOPSY FIN AMAILABLE PRIOR TO COMPLETION DE CAMPLETION DE CAM		
BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICAT	Abock, or heer falls IMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not determine 29a. CERTIFIER (Check only One) 2 MEDICAL EXA 29 SIGNATURE AND TITLE OF CERTIFIER (Check only One) 1 CERTIFYING P (Check only One) 2 MEDICAL EXA 30. NAME AND ADDRESS OF PERSON	AL HOSPITAL: 1 Inpetient 2 E 1 Month, Dey, Iton 28a. PLACE OF I building, etc 28a	R AS A CONSEQUENCE OF R AS A CONSEQUENCE OF	RAYM 426 not enter the mo CL COT F): In the underlyin 26. Pi OTHER: 4 (Phursing Non IE OF Street, fectory, office ed at the lime, data on, in my opinion, of	GOND C CRAIN F Dide of dying, such controls g cause given in LACE OF OEATH (C) ne 5 Raeldence JURY AT DIK? YES 2 NO se and place, and duck death occured at the 29c. LICENSE NU DICENSE NU	Part I. 24a. W Per I V Peck only one) 6 Other (Specific City or Yown, or to the cause(a) and time, data and pla MBER 786	US AN AUTOPSY REORMED? ES 2 PNO DIOW INJURY OCCUP Direct and Number or State) d menner as stated. Co, and due to the co	24b. WERE AUTOPSY FINANTIA BLE PRIOR TO COMPLETION DE COMP		



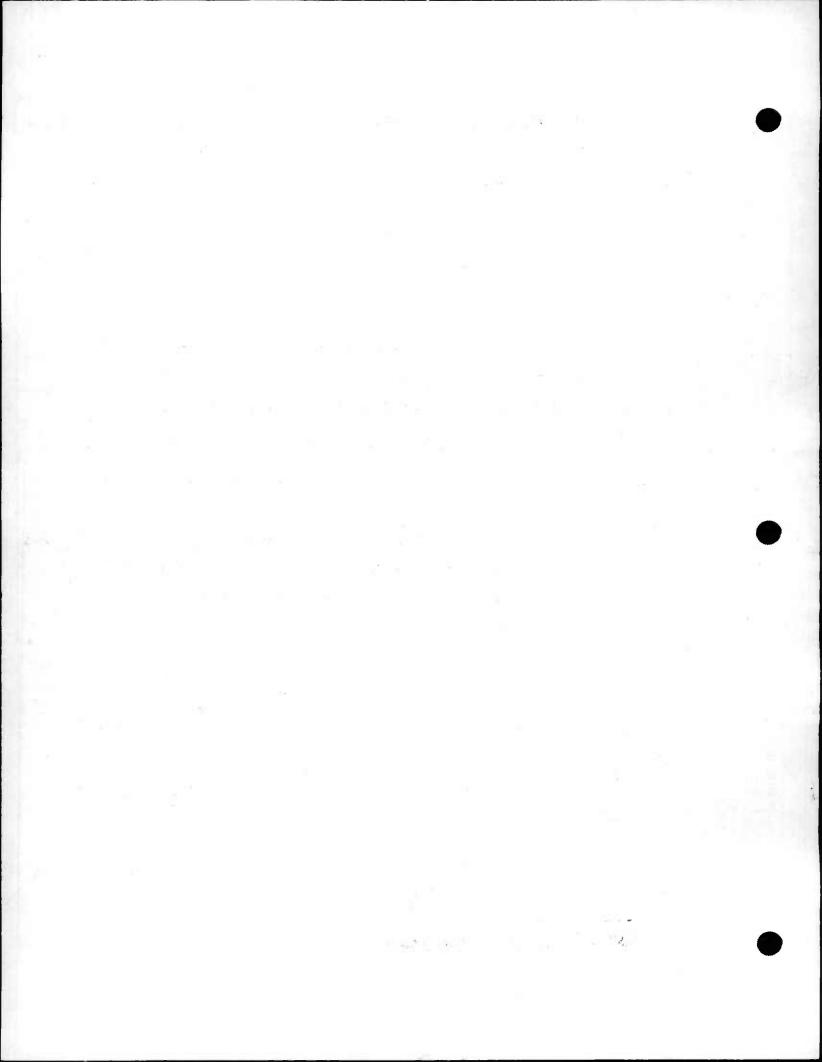
FOR STATE REGISTRAR

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CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR VERNON AUGUSTUS LAWSON 6.02 pm JULY 1995 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH
(Month, Day Year)
OCt. 9, 1907 6. AGE (In vrs. last hirthday) IF UNDER 1 YEAR DAYS HOURS Maryland 1 XM 2 - F 213-10-6121 87 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Harbor Hospital Center Balto.City, Md. none RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Balto.City, Md. none 1 K YES 2 □ NO use as the burial-transit permit. FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10g CITIZEN OF WHAT COUNTRYS United States 1705 Covington St. 21230 hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, atc.)

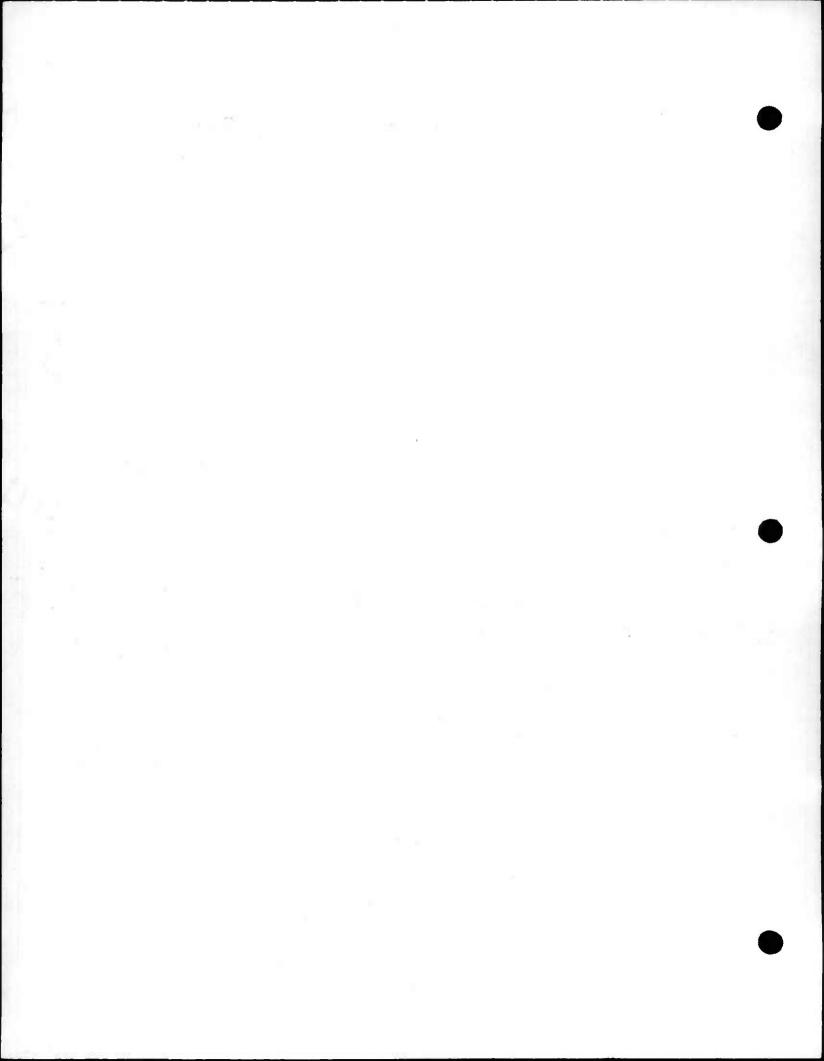
1 YES 2 NO Specify: 14. RACE — American Indian, 1 Never Married 2 Married В Specify: White 3 Nidowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Spec Elementary/Secondary (0-12) College (1-4 or 5 +) 6th.Grade None Rivetter, Ship Yard Maryland Drydock once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) at Charles Augusta Lawson Hattie Regina Collins BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 Mrs.Margaret C.Lawson 1705 Covington St.Balto.Md.21230 99 20c. LOCATION — City or Town, Stata 20b, PLACE AND DATE OF DISPOSITION (Name of DATE must Dulaney Valley Cemt.8/2/95 Timonium, Balto.Co. medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Balto.Md.21230 McCully Funeral Home, 130 E. Fort Ave in by the 23. PART I Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or reapiretory arrest, Approximate ahock, or haert fallura. Liat only one ceuse on each line. ŏ completely filled **IMMEDIATE CAUSE (Final** Onset and Death the cremation. disease or condition CARDIO GENIC
DUE TO (OR AS A CONSEQUENCE OF): executed within resulting in death) SHOCK traumatic event, burial. HYPERTENSIVE CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION and Sequentially list conditions, prior to if any, laeding to immediate cause. Enter UNDERLYING certificate has been signed by the attending physician the State Dept. of Health and Mental Hygiene prior to 2 CONCESTIVE
DUE TO (OR AS A CONSEQUENCE OF): HEART FAILURE certificate CAUSE (Disease or injury other t thet initiated eventa resulting in death) LAST ATRIAL FIBRILLATION 0 death (Injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. the MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS that AMILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 YES 2 10 requires I YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: WE 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The Hem HOSPITAL: **EXAMINER?** OTHER: 1 YES 2 NO PHYSICIAN: Inpatient 2 - ER/Oulpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY with b 26b. TIME OF 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural Pending Investigation 1 YES 2 NO DIRECTOR: After the hours after death vitem 28 is mark BY HOSPITAL OR ATTENDING 2 Accident 3 Suicide 28a. PLACE OF INJURY — At home, larm, streel, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL DE BE filed within 72 ho 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER CoHarathis 29d, DATE SIGNED (Month Day Year) BE Thomas 2441614-32 10 1995 29 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. HANOVER STREET, BALTIMORE 31. DATE FILED (Month, Day, Year) - -32. REGISTRAR'S SIGNATURE DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death contingent to recover when the death, Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to	be filed within 72 hours after death with the State Dept. of Health and Mental Hypnens prior to burial, cremation, or rempas	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical coaminer must be notified at once.
TO THE HOSPITAL DR ATTENT	TO THE FUNERAL DIRECTOR:	be filed within 72 hours after	IMPORTANT: If Item 28 is

							95	23083	
	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	TMENT OF H	FEALTH AND I	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) JOSEPH		LAZEI			2. DATE OF DEATH MONTH D.	r oe	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. B	HRTHPLACE (State or Foreign	
	239-22-0843 9e. FACILITY NAME (If not institution, give stree	1 X M 2 D F	73 YRS.		OR LOCATION OF DE	(Month, Pay Year) 4-24-22	9c. COUNTY (N.C.	
TOR	UNION MEM. HOSPITA	AL .	-	BALTI	MORE		BALTO). CITY	
DIRECTOR	100, STATE 100, COUNTY WD BALTO	O. CITY		Y, TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS?	
	10a. STREET AND NUMBER	J. CITI	D/		, ZIP CODE		10g. CITIZEN	1 ⚠ YES 2 ☐ NO OF WHAT COUNTRY?	
FUNERAL	2121 WINDSOR GARDE			13 WAS DEC	FNDENT OF HISDAM	IC ORIGIN? (Specify Yes		5.A.	
BY FI	1 Never Merried 2 X Married 3 Wildowed 4 Divorced	FORCES? 1 (X) YES	2 NO DATES	If yes, sp	ecity Cuben, Mexican 2 NO Specify	n, Puerto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify: R. AMERICAN	
	15. DECEDENT'S EDUCAT (Specify only highest grade co.	TION mpleted)	16e. DECEDENT'S (Give kind of	USUAL OCCUPATION OF PRINTING TO THE PRINTING T	ON est of working	16b. KIND OF BUS			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	LABOI			SHIPY	ARD		
BE CO	17. FATHER'S NAME (First, Middle, Lest) GEORGE LEAZER				16. MOTHER'S NAM	ME (First, Middle, Meiden LEAZER	Sumeme)		
TO E	190. INFORMANT'S NAME (Type/Print) BEATRICE LEAZER					Oute Number, City or Tow ANE APT.		,	
	20s. METHOD OF DISPOSITION 1 A Burlel 2 Cremation 3 Remove 4 Denetion 5 Other (Specify)	al from State	PEACE AND DATE (intery, crematory, or o		7-26-95		CATION — City o		
	21 SIGNATURE OF FUNERAL BENVICE LICEN		/	Charles of the latest of the l	P BROTHER	FUNERAL			
	23. PART I. Enter the diseases, or con	Mall	1	1300	EUTAW PL	ACE BALTO	. MD 21	217	
	sbock, or heart failure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death)	A SCV	aconsequence of		de or dying, such	i se cardiac or respi	ratory arrest,	Approximate Interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
	PART II. Other significant conditions of	contributing to death t	out not resulting i	n the underlying	g cause given in i	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
PHYSICIAN: MEDICAL	hlind 26 ahi	1 coma,	IKM	C 00	ET'S	1 🗆 YES 2	Pull	COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 NO	
AN: A	DID TOBACCO USE CONTRIB			S- NO [UNCERTAIN			1 TYES THO	
SICI,		IOSPITAL:	26. PLACE DF DEAT	OTHER:	e 5 🗆 Residence (8 Other (Specify)			
	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJ URY WO	URY AT RK?	28d. DESCRIBE HOW II	NJURY OCCURE	0	
TED BY	2 Naccident Investigation M 1 YES 2 NO 3 Suicide 8 Could not be datermined Building, etc. (Specify) City or Town, State) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA (Check only one) 2 MEDICAL EXAMINER:	N: To the best of my know	rledge, death occurre	d at the time, date	end place, end due t	to the cause(e) end men	ner ee stated.	se(e) and menner es stated.	
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Hon	1		29c. LICENSE NUM		- 10/11	NED (Month, Day, Year)	
10	30. NAME AND ADDRESS OF PERSON WHO O				_ V JUT	17	7/0	4173	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE	טויו					
(ALLO A TIGOR JALVA	d'anciente	7 111						



DIVISION OF VITAL RECORDS, P.O. BOX 68760

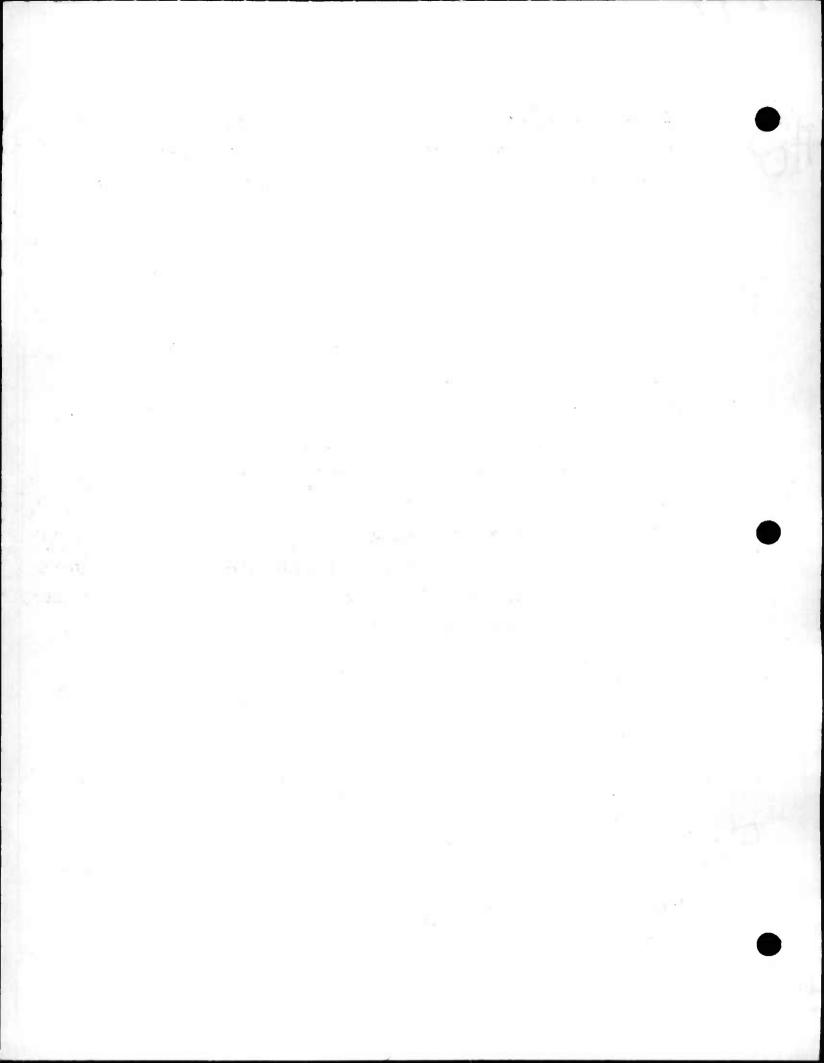
) THE HDSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	0 THE FUNEAAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit, Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL	TO THE FUNERAL	be filed within 72 t	IMPORTANT: If I

	FOR STATE OF N	IARYLAND / D	FPART	MENT OF L	IFAITH AND	MENTAL	HAGIENI	95	2	3084
	REGISTRAR	CER	TIFIC	CATE OF	DEATH	MENIAL	REG. NO.		_ =	
	1. DECEDENT'S NAME (First, Middle, Last) IDA LINDSAY					2. DATE OF MONTH			YEAR 195	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs. last bit	rthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE C	E BIRTH		8. BIRTHP	LACE (State or Foreign
	215-10-7198 10M2X1F	82	YRS.	MONTHS DAYS	HOURS MIN.	SEP	r. 6,1	912	MAF	RYLAND
<u>د</u>	9a. FACILITY NAME (If not institution, give street and number) SINAT HOSPTTAL.			9b. CITY, TOWN (BALTIMOF			9c. COUN	ITY OF DE	
16	RESIDENCE OF DECEDENT				DALITION	Œ			N/	A
DIRECTOR	MARYLAND BALTIMORE	1	0c. CITY,	BALTIMO				1		10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER				ZIP CODE			10a. CITIZ		1 YES 2 NO
FUNERAL	6643 SANZO ROAD				21209)			SA	
F	11. MARITAL STATUS 12. WAS DECEDENT 1 Never Married 2 Married FORCES? 1	EVER IN U.S. ARMEI	D		ENDENT OF HISPAN			or No-	14. RACE - Black.	- American Indian, White, atc.
B	3 X Widowed 4 Divorced IF YES, GIVE W				2 NO Specifi		, , , ,		Specify	
E	15. OECEDENT'S EDUCATION (Specify only highest grade completed)	16e. DECEE	DENT'S U	SUAL OCCUPATION	ON	16b.	KIND OF BUS	INESS/IND	USTRY	WHITE
Ē	Elementary/Secondary (0-12) College (1-4 or 5 +	We. Do	NOT use		st of working					
COMPLET	12	SA	LESF	PERSON			ONROE			
1 - 1	17. FATHER'S NAME (First, Middle, Last) FRANK SF	URKIN			18. MOTHER'S NA ROSE	ME (First, M	iddie, Maiden S	-,	- 2 MDD	
BE	19a. INFORMANT'S NAME (Type/Print)		AILING A	ADDRESS (Street a	nd Number or Rural I	Boute Numbe	c Clly or Foun		RAMER	
2	MRS. LOIS GOLDSTEIN				T., N.W.					20016
	20s. METHOD OF DISPOSITION 1 Aburlat 2 Cremetion 3 Ramoval from Stata 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of camelery, crematory or other place) ARLINGTON—CHIZUK AMUNO 7-28-1995 BALTIMORE, MD									
	4 Donation 5 Other (Specify)	ARLING	TON-	CHIZUK	AMUNO 7-	-28-19	95 BA	LTIM	ORE,	MD
	21. SIGNATURE OF FUNERAL SERVICE ALCENSEE				EVINSON		DS., I	NC.		
Н	C BU MAW NI-			6010	REISTERS	NWOTE	ROAD	BALT	EMORE	, MD 21215
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, interval Between interval Between interval Between interval Between interval									
	IMMEDIATE CAUSE (Fine) disease or condition	CANIC	Er							Onset end Death
	resulting in death) a. LUNG	OR AS A CONSEQUE	NCE OF):	<u> </u>						1991
Z									DAYS	
CERTIFICATION	any reading to minimediate									
I S	CAUSE (Disease or injury that initiated events	FF CO	NCE OF:	113						3 WEEKS
E		NUTR								
2	PART II. Other significent conditions contributing to				a parine about la	Dord I				
CAI		seem but not resu	anny m	the underlying	ceuse given in		PERFORM	AED?	- A	VERE AUTOPSY FINDINGS WAILABLE PRIDR TO COMPLETION OF CAUSE
						- 1	1 YES 2	NO	0	F OEATH?
PHYSICIAN: MEDICA	DID TOBACCO USE CONTRIBUTE TO CAL	JSE OF DEATH	YES	□ NO □	UNCERTAIN	V X				L 125 2 NO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE O		(Check only one)						
IXSI		ER/Outpetient 3 🗆	DOA 4	□ Nursing Hom	e 5 🗆 Rasidenca					
ВУ РН	27. MANNER OF OEATH 1 Netural 5 Pending 2 Accident Investigation		INJUF	RY WO	URY AT RK? 'ES 2 NO	28d. DESC	RIBE HOW IN	JURY OCC	URED	
ETED E	2 Accident 3 Suicide 8 Could not be determined 28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28b. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)								ite Number,	
PLE	29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of r	ny knowledge, death	occurred	st the time, data	and place, and dua	to the caus	e(a) and mann	or as state	d.	
COMPL	one) 2 MEDICAL EXAMINER: On the basis of axi									and menner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER LEMAN THE CONTROL OF CERTIFIER T	1.M	٥.		DEA A	BER 240	2321	≥9d. DATE	SIGNED (A	Aonth, Day, Year) 26, 1995
10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUS	E OF DEATH (ITEM 27	(Type, P		DA 991		NEDE	10 A	Tuc	21215
	WEELD THE THE SHIP	1100111		=/ 4 T 0	AA.DE	LVE.	PCKE.	/PH	LIM	CKC, MD



DEEPA ABRAHAM
31. DATE FILED (MORITI, Day, Year)
AUG 0 1 1995

SINAL HOSPITAL

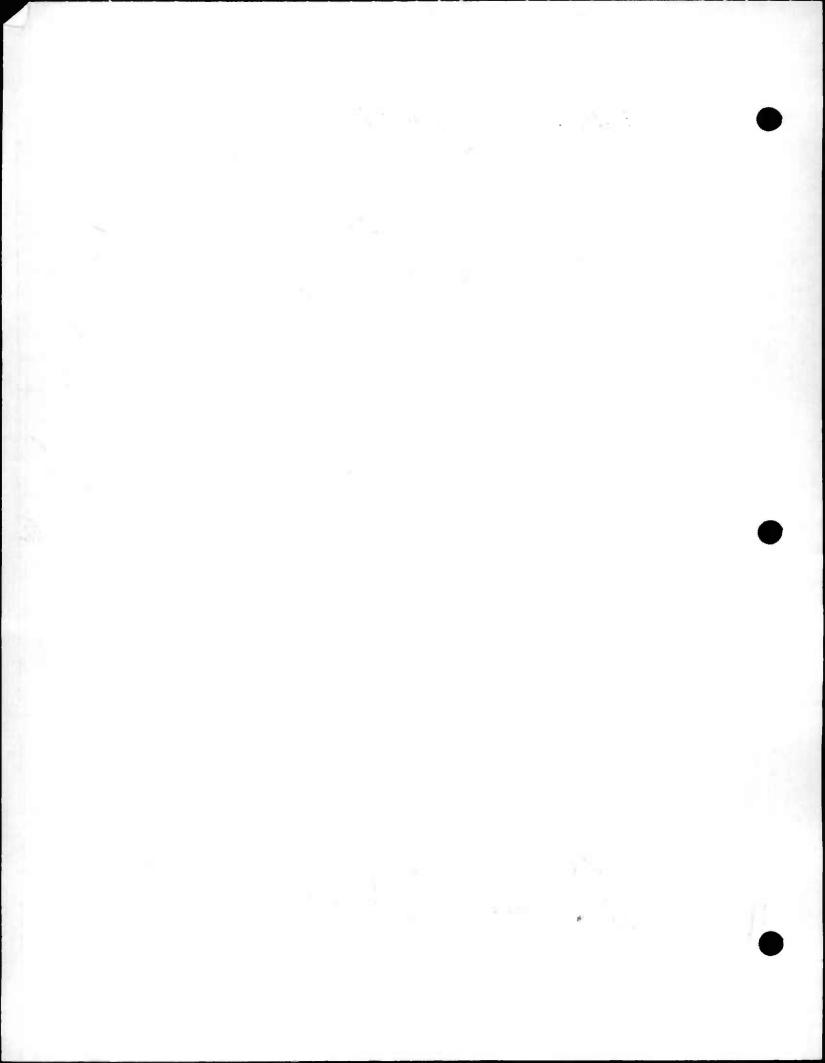


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DIVISION OF VITAL RECORDS. P.O. BOX

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR	CERTIF	ICATE OF D	EATH	REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Lest) ELYARD	MARIN	IE T		ATE OF DEATH	YEAR 3.	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 5. SEX 2U7-05-5-6-01 12 M 2	8. AGE (In yrs. last birthday) F YRS.		UNDER 24 HRS. 7. D/	ATE OF BIRTH fonth, Day, Year)	6. BIRTHPLI Country)	ACE (State or Foreign
3 should		ga. FACILITY NAME (If not institution, give street and number)	0	9b. CITY, TOWN OR LO	OCATION OF DEATH	pil 6, 191	COUNTY OF DEAT	5,C.
1, 2,	DIRECTOR	RESIDENCE OF DECEDENT	Nursing Home	BA for	7.		NA	
ift. Pages		10a. STATE 10b. COUNTY NA.	10c. CIT	y, town or location				d. INSIDE CITY LIMITS? YES 2 NO
n. Insit permit.	FUNERAL	725 Belgian A	ve		CODE 1218	10g.	CITIZEN OF WHA	
DENysician.		1 Never Married 2 Married FORCES?	DENT EVED IN U.S. ARMED 1 YES 2 NO VE WAR OR DATES	13. WAS DECENDED If yes, specify 1 YES 2 A	Cuban, Mexican, Pue	IGIN? (Specify Yes or No rto Rican, etc.)	- 14 BACE -	American Indian, hita, etc.
attending se as the	D BY	3X Widowed 4 Divorced	7		NO Specify:		13/1	ik
- b -	ETED	15. DECEOENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or	(Give kind of v	USUAL OCCUPATION work done during most of se retired.)	working	EASTER		ch
a B	립	12		bor		DEPAR	+ men	T
by the		17. FATHER'S NAME (First, Middle, Last)	inest.	18.	MOTHER'S NAME (FI	st, Middle, Meiden Surner	me)	di
retained 5 should notified	70 BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street and N.	lumber or Rural Route N	umber, City or Town, State	e, Zip Code)	oug
y be re sage 5	-	MICHAEL MAKINE 20a. METHOD OF DISPOSITION		Belq1	An Ave	BA 110.1	1/212	17
must		1 Duriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	capetery, crematory or of	of DISPOSITION Name of their place)	1.0.0- 8	ATE 20c. LOCATION	N — City or Town,	State 11.chcl
the death. Page 6 m the funeral director, oval.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE			DORESS OF FACILITY	and B	400	21912
the fur deal the fur all exa	Щ	(Yaththe B	to	11291	.CARSI	10 55.0	1/on	1
24 hours after filled in by the on, or removal		23 PART . Entar tha diseases, or complicatione shock, or heart failure. List only one	that caused the deeth. Do r	not anter the mode of	of dying, such as o	erdiac or respiratory	y arrest,	Approximata interval Between
file file		IMMEDIATE CAUSE (Finei disease or condition	SO	NO				Onset and Death
completely ial, cremati		resulting in death) a. DUE	TO (OR AS A CONSEQUENCE OF	F):				J purvice
e be executed sician and con nior to burial, traumatic ev	NO.	Sequentially flat conditions, DUE	TO (OR AS A CONSEQUENCE OF	n:				
hysician prior i	CAT	cause. Enter UNDERLYING CAUSE (Disease or injury						
h certificat ending phy Hygiene p	ERTIFICATION	that initiated events resulting in death) LAST	TO (OR AS A CONSEQUENCE OF	F):				
the death y the atter d Mental	O	d.						
# 4 5 5	DICAL	PART II. Other eignificent conditione contributing	to death but not resulting i	in the underlying cer	use given in Part i.	PERFORMED?	AVA	RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE
Sign Sign	MED	Demontie				1 TYES 2 NO	OF	DEATH? YES 2 NO
Is b		DID TOBACCO USE CONTRIBUTE TO (25. WAS CASE REFERRED TO MEDICAL			JNCERTAIN 🗆			
SICIAN: The certificate h the State th d, or item	SICIAN:	EXAMINER? HOSPITAL:	28. PLACE OF DEAT	OTHER:				
PHYSICIA this certif with the rked, or	РНҮ	27. MANNER OF OEATH 28e. DATE	OF INJURY 28b. TIME	4 Nursing Home 5 E OF 28c. INJURY WORK?		Ther (Specify) DESCRIBE HOW INJURY	OCCURED	
DING PHYS After this death with	ВУ	2 Accident Investigation		M 1 TYES				
CTOR: after 28 i	ETED	3 Suicide 6 Could not be determined	E OF INJURY — At home, farm, a ng, atc. (Specify)	treet, factory, offica	28f. L	OCATION (Street and Nur lity or Town, State)	mber or Rural Route	Number,
보 보 2 =	MPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best	of my knowledge, death occurre	ed at the time, data and p	place, and due to the	cause(a) and menner as	stated.	
HOSPITAL FUNERAL Within 72 I	8	2 MEDICAL EXAMINER: On the beals o	f examination and/or investigation					
TO THE HOSPITAL TO THE FUNERAL De filed within 72 I	TO BE	/ Idan	MO	290	2756	9 29d.	12X1	nth, Day, Year)
.\	-	DO. NAME AND ADDRESS OF PERSON WHO COMPLETED CO	AUSE OF DEATH (ITEM 27)	JE28				
4 1		31. DATE FILACION DEL VISOS	authorit had all	W 36	v .			
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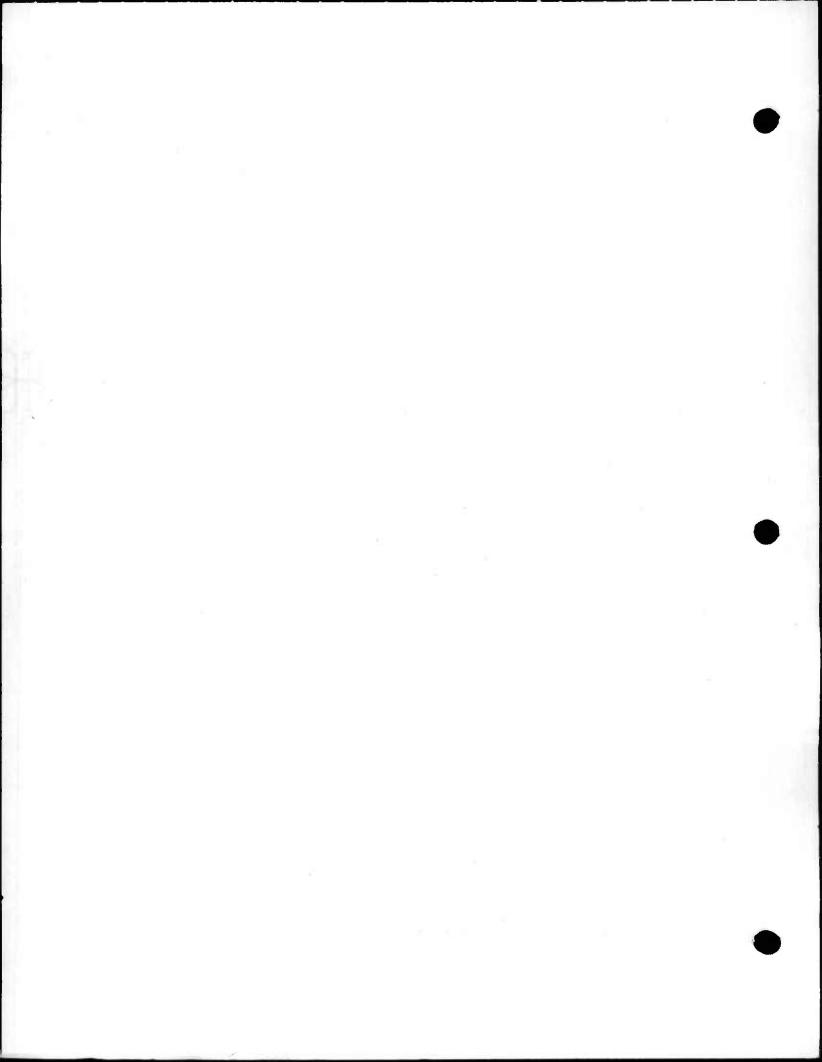


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	ITEM: 1. PER F.H. FILM G-726 8/1/95 t	.t				2.0000			
	1 . STATE SIMIE OF MARTLAND /	DEPARTMENT OF ERTIFICATE O	F DEATH	MENTAL HYGIEN REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last) JERRY AUSTIN	MARTI	2	2. DATE OF DEATH MONTH D.	NY 95 YEAR	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 216 → 52 → 4408 1 M 2 □ F 47	YRS. IF UNDER 1 YEAR MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year) Feb. 21. 1		HPLACE (State or Foreign			
OR	90. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center 8b. CITY, TOWN OR LOCATION OF DEATH Randallstown 8c. COUNTY OF DEATH Baltimore								
DIRECTOR	10a. STATE 10b. COUNTY	10c. CITY, TOWN OR LO	CATION			10d. INSIDE CITY			
L DI	Maryland Baltimore 100. STREET AND NUMBER	Dundalk	10f. ZIP COOE			LIMITS?			
NERA	4106 Eder Road		21222		United	States			
BY FUNERAL	11. MARITAL STATUS 1 \[\frac{N}{Never Merried} \ 2 Merried \\ 3 \text{Widowed} \ 4 \text{Divorced} \\ 12. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \ 2 \text{N} \\ 15. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \ 2 \text{N} \\ 16. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \ 2 \text{N} \\ 17. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \ 2 \text{N} \\ 18. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \ 2 \text{N} \\ 19. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \ 2 \text{N} \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \ 2 \text{N} \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \ 2 \text{N} \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \ 2 \text{N} \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \ 2 \text{N} \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \ 2 \text{N} \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \ 1 \text{YES} \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES? \\ 10. WAS DECEDENT EVER IN U.S. ARI FORCES \\ 10. WAS DECEDENT EVE	VO It yes,	ECENDENT OF HISPA specify Cuban, Mexico (ES 2 NO Specific	NIC ORIGIN? (Specify Yes in, Puerto Ricen, atc.) y:	s or No— 14. RAC Blac Spec	E — American Indian, k, Whita, etc. ity: White			
COMPLETED	(Specify only highest grade completed) (Gi	CEDENT'S USUAL OCCUP, ive kind of work done during Do NOT use retired.) Sabled	ATION most of working	None	SINESS/INDUSTRY				
BE COM	17. FATHER'S NAME (First, Middle, Last) Austin Martin, Ir.		18. MOTHER'S NA Esther	ME (First, Middle, Maiden Mae Kraffd	Sumame)				
TO B	190. INFORMANT'S NAME (Type/Print) Mr. and Mrs. Austin Martin, Jr. 4	b. MAILING ADDRESS (Stro 1106 Eder Ro	end Number or Aural Oad Baltin	Ploute Number, City or Tow.	n, State, Zip Code) Land 2122	2			
	4 Donation 5 Other (Specify)	AND DATE OF OISPOSITION matory or other place) WN Cemeter			cation - chy or to	Maryland			
	21. SIGNATURE OF HAMINAL SERVICE LICENSEE	Dude	AND ADDRESS OF FA	ounv ieral Home inue Dundal	of Dunda	lk, Inc.			
	23. PART I. Enter the diseases, or complications that caused the de- shock, or heart failure. Liet only one cause on each line.	ath. Do not anter tha	mode of dying, auc	h as cerdiac or reapi	ratory arrest,	Approximate Interval Between			
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. RESPIR.		FAIL	URE		Onset and Death			
NOI	Sequentially list conditions, fi any, leading to immediate	, 							
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSEC	DUENCE OF):			*				
CER	resulting in deeth) LAST								
PHYSICIAN: MEDICAL	SCHIZO PHRENIA CHT	esulting in the underly	ing cause given in	Part I. 24a. WAS AN PERFOR 1 TYES 2	MED?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
N.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEAT	TH YES INO	UNCERTAI	V 124	<i>'</i>	1 UYES 2 DINO			
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE HOSPITAL:	E OF OEATH (Check only or		7-1					
PHYS	1 ☐ YES 2 ☐ NO 1 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	28b. TIME OF 28c.	NJURY AT WORK?	6 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCUREO				
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined		YES 2 NO	28t. LOCATION (Street a City or Town, State)	nd Number or Rural F	loute Number,			
COMPLETED	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, dea								
E CO	2 MEDICAL EXAMINER: On the basic of examination and/or in	nvestigation, in my opinion	death occured at the		d due to the cause(a				
TO BE	30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM	()	177	373	▶ JULY	28, 81			
	C- RAVIMO NH	tc, BA	LTO. N	40 2113	3				
	AUG U 1 1995 Jahr Walter Rayles								
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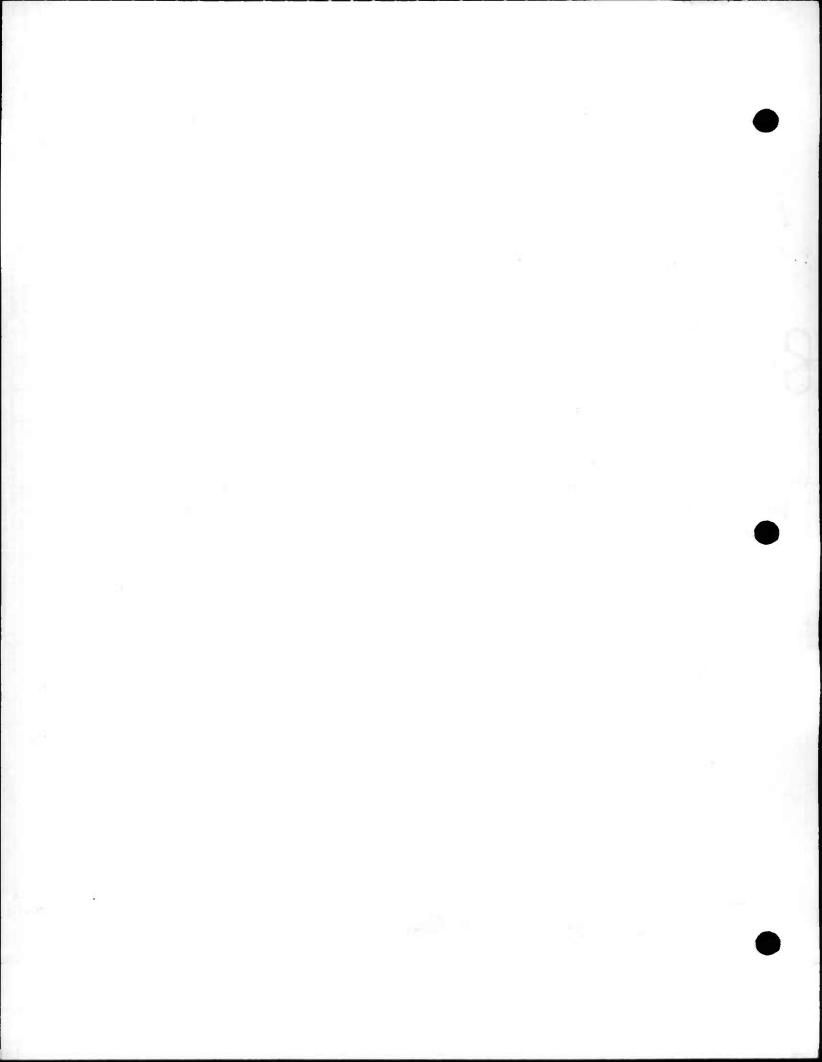
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	FOR	STATE OF I	MARYLAND /	DEPAR	TMENT (UE H	EALTH	AND	MEN	TAL HVCIEN	40	Ü	23081
	1 - STATE REGISTRAR		CI	ERTIF	ICATE	OF	DEAT	ГН	IMEN	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) BLANCHE RODGE	RS MOWB	RAY							ly 28,	19	95	3. TIME OF DEATH 3:15 pm
	4. SOCIAL SECURITY NUMBER 214-03-4781	5. SEX 1 □ M 2 🔯 F			IF UNDER 1 1	YEAR DAYS	IF UNDER	24 HRS.	7. DA	TE OF BIRTH		6. BIRT	
	Se. FACILITY NAME (If not institution, give	1 41	90	rna.	9b. CITY, TO	OWN O	R LOCATIO	ON OF D	Aug	g. 31, 1	1904 Maryland		
9	Manor Care Towson				Tows			011 01 01	LAI!!				imore
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN OR		ION		-				10d. INSIDE CITY
		timore		Ba	altimo	ore							LIMITS?
RAL	10e. STREET AND NUMBER					101.	ZIP CODE				10g. CI	IZEN OF	WHAT COUNTRY?
10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF 10g. CITIZEN OF 21212 U.S. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No													
	1 Never Married 2 Married	FORCES? 1	YES 2 X	10	lf y	res, spe	city Cuba	n, Mexica	en, Puar	rto Rican, atc.)	or No-	14. RAC Blac Spec	E — American Indian, k, White, atc.
D BY	3 🔯 Widowed 4 🗌 Divorced		100 120 120 100					Орвен					white
COMPLETED	15. DECEDENT'S EDL (Specify only highest grade Elementary/Secondary (0-12)	completed)	(G	CEDENT'S Ive kind of Do NOT us	Work done dun se retired.)	UPATIO	N it of workin	g	1	16b. KIND OF BUS	SINESS/IN	DUSTRY	
필	8 years	College (1-4 or 5	.,	rica	1					Advert	isin	O.	
8	17. FATHER'S NAME (First, Middle, Last)								ME (Firs	st, Middle, Maiden			
BE	Harry Winfield Ro	dgers Sr.		***			Mae				W	alte:	rs
2	Orville Mowbray	(sc								umber, City or Town)
	20a, METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Ram		20b. PLACE	ND DATE	OF DISPOSITI	ON /Nen	ne ol		_ D	ATE 200 LO	CATION	Ohu or Tr	num Bauta
	* Donation 5 Other (Specify)		Druid	Rid	ge Cen	nete	ery A	lug.	1,	'95 Pil	kesv:	ille.	Maryland
1 1	21. SIGNATURE OF BOWERAL SERVICE LI	()			22. NA	ME AND	D ADDRES	SS OF FA	CH ITY	ld Home			
- 3	Mums /.	Dark			650)O Y	ork	Rd.	Ва.	ltimore	, MD	2121	12
	23. PART I. Enter the diseases, or shock, or heart failure.	List only one cau	it caused tha de lae on each line	ath. Dor	not anter th	a mod	le of dyl	ng, suc	h as c	ardiac or reapl	ratory ar	rest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)		25 ca										Onset and Daath
z		DUE TO	(OR AS A CONSEC	DUENCE O	F):								
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CONSEC	DUENCE OF	F):								
FI	CAUSE (Disease or Injury that initiated events	c. DUE TO	(OR AS A CONSEC	UENCE O	F):								
E	resulting in death) LAST	d,											
AL C	PART II. Other significant condition	s contributing to	death but not re	eaulting I	In the unde	riying	cause g	lven in	Part I.	24s. WAS AN		24b	. WERE AUTOPSY FINDINGS
MEDICA	Stage 4	pressul	e sa	e,						PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
ME	DID TODACCO HEE CONT	DIDLITE TO CA	LICE OF DEA										1 _ YES 2 _ NO
IAN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	KIBUIE IO CA			H (Check only		UNC	ERTAIN	и Ц				
PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:	g Home	5 🗆 Res	sidenca	6 🗆 01	ther (Specify)			
	27. MANNER OF DEATH 1 X Natural 5 Pending	28a. DATE OF (Month, D		28b. TIM INJ	E OF 28 URY	ic. INJU WOR	RY AT			ESCRIBE HOW IN	JURY OC	CURED	
D BY	2 Accident Investigation 3 Suicide a Could not be	28e. PLACE O	F INJURY — Al hor	me, farm, s			ES 2 _	NO	26f. L	OCATION (Street a	nd Numbe	r or Rural F	South Number
Ĭ.	4 Homicide determined	building,	etc. (Specify)						a	ity or Town, State)			1011000
COMPLETE	29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSIC MEDICAL EXAMINE) and menner as stated.
E CC	29b. SIGNATURE AND TITLE OF CERTIFIE	_				-	29c. LICE			The same proces, and			(Month, Day, Year)
10 Bi	- NA							110				7 ,3	
	Theodore C. Ho	uk M.D.	7825	York	Rd.	7	ows	on	MI	D 21204	4		
	31. DATE FICED (Month, Day, Year)		R'S SIGNATURE	,									
	AUG 0 1 1995	Jana avan						_					
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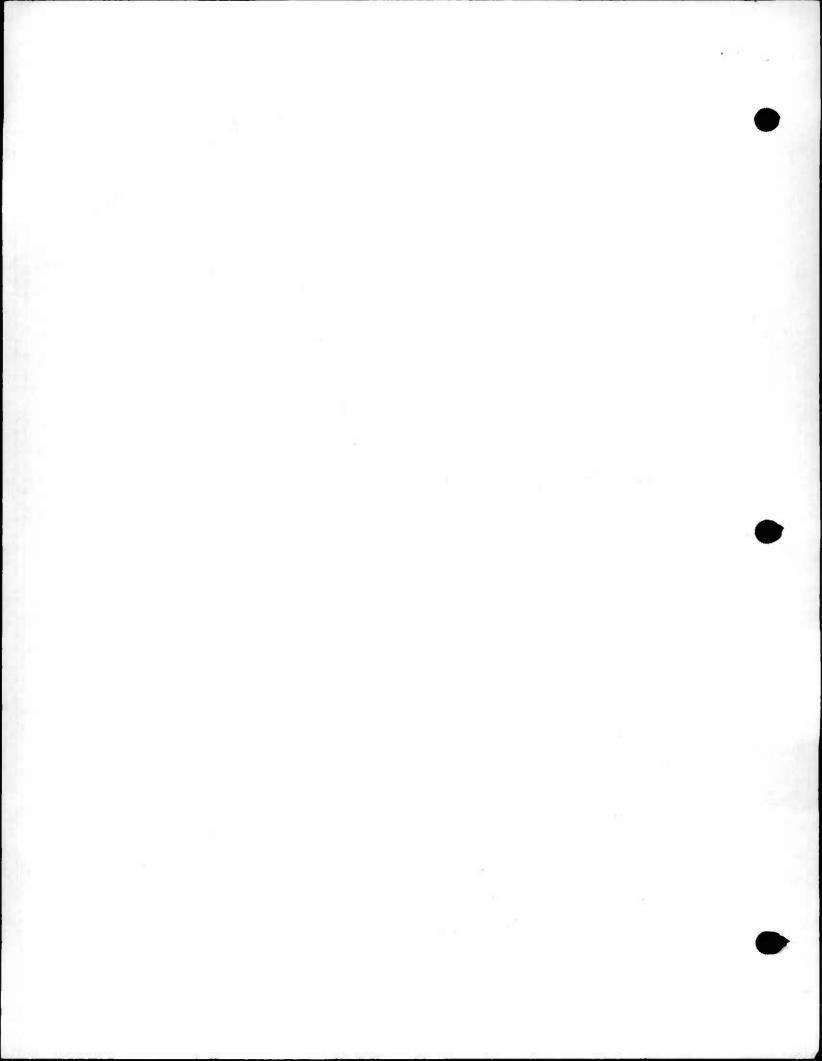
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P.O. BOX 68760	Partific
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T C	that
VITAL RECORDS, P.O.	we required that the death certificate he executed within 34 hours after
1	SAM P
A	The
	DEPITAL OR ATTENDING PHYSICIAN: The
DIVISION	NDING
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	G
	OSPITAL

		1 - FOR STATE REGISTRAR	STATE OF MARYLAND	DEPARTMENT	NT OF H	HEALTH AND		HYGIENE REG. NO.		
	-	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF		YEAR	3. TIME OF DEATH
		Samuel Hamilton	N Wortimer, Jr				July	26 1	995	12:06 p M
pinous			× 1 2 □ F 76	YRS. MONTH		IF UNDER 24 HRS. HOURS MIN.		16 191	18 N	Maryland
1, 2, 3 shc	TOR.	The second secon								
Pages	ERAL DIRECTOR	10a. STATE 10b. COUNTY	ltimore	Baltimo		TION				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
nsit permit,		106. STREET AND NUMBER 7114 Rock Ridg	je Rd.		101	21207	100	10g. CITIZEN OF WHAT COUNTRY?		
Z15-UUZU attending physician. se as the burial-transit	BY FUNER		2. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2 I IF YES, GIVE WAR OR DATES WW 11		It yes, sp	CENDENT OF HISPAN ecity Cuban, Maxica 2 (NO Specify	n, Puerto Rica	Specify Yes or N in, etc.)	lo— 14. RAG	CE — American Indian, ick, white, atc.
AND ZIZIS-U the hospital or attending detached for use as the once.	8	15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12)	ION 18a. DI	ECEDENT'S USUAL Give kind of work dor te. Do NOT use retired	ne during mo			NO OF BUSINES		ng & Communit
he hospital detached force.	COMPLET	12		Engineer		spector)			e of M	
_ 0 +		17. FATHER'S NAME (First, Middle, Last)	- Martimore Cu			18. MOTHER'S NA			,	ment)
retained by 5 should b	BE	Samuel Hamilton 19a. INFORMANT'S NAME (Type/Print)			SS /Street a	Mary E				
be reta ge 5 st	유	Patricia J. Mort				idge Rd.)7
Page 6 may be all director, page ner must be r		20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ramoval 4 Donation 8 Other (Specify)	t from Stata 20b.PLACE cametery, cre Dular	AND DATE OF DISP	OSITION (Ne	me of 7/29	/95PATE	20c. LOCATIO	ON — City or 1	
death. e funeri		21. SIGNATURE OF FUNERAL SERVICE/LICENS	Clary	2	Lemm	on Fune	ral Ho	me		MD 21093
24 hours at y filled in by tion, or remo		23. PART I. Enfer the diseases, or company the state of t	nplications that caused the det only one cause on such line	aath. Do not ant a.	ar tha mo	titame	h aa cardiac	or reapirator	y arreat,	Approximata interval Between Onset and Death
executed and con burial,	CATION	Sequentially list conditions,	DUE TO (OR AS A CONSE	OUENCE OF):						
ficate be physician ne prior to	ICAT	If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury								
	ERTIFI	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSE	OUENCE OF):						
E 5 - 6	CE	d								
T P T	EDICAL	PART II. Other algnificant conditions co	ontributing to death but not i	raaulting in tha	undariying	g cause givan in		PERFORMED?	?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH?
> 11 00	≥	DID TOBACCO USE CONTRIB	SUITE TO CAUSE OF DEA	ATH VES [NO 🗆	UNCERTAIN				1 TES 2 NO
De De	CIAN:	25. WAS CASE REFERRED TO MEDICAL	28. PLAC	CE OF DEATH (Chec		DINCERIAM	, L			
SICIAN: The certificate the State , or Item	YSICI	1 - YES 2 NO 1	OSPITAL: tripetiant 2 ER/Outpetiant 3	OTHI	ER: ursing Home	e 5 XAssidence	8 Other (Sp	pecify)		
The with the control	ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. tNJI WOI 1 Y	URY AT RK? /ES 2 NO	28d. DEŞCRI	BE HOW INJURY	Y OCCURED	
OR ATTENDING DIRECTOR: After hours after death	ETED 8	3 Suicide 8 Could not be 4 Homicide datarminad	28a. PLACE OF INJURY — At ho building, atc. (Specify)	oma, farm, atreet, ta	ectory, office			ON (Street and Nu own, State)	imber or Rural	Route Number,
TAL OR AL DIR 72 hour	COMPLE		N: To the best of my knowledge, de On the basis of examination and/or							(a) and manner as stated.
TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: If	BE C(29b. SIGNATURE AND TITLE OF CERTIFIER	,	***	I	29c. LICENSE NUM				D (Month, Day, Year)
E E S S E E E E E E E E E E E E E E E E	6 B	- PAL + (MD			D418	87	>	7/2	6/95
		Rafael J. Tamar	MPLETED CAUSE OF DEATH (ITE	M 27) (Type, Print)	The	Johns St./M	HOPK	7-113/	Balto	MD 21287
		31. DATE FILED (Month, Day, Year) AUG 0 1 1995	TIL REGISTRAN'S SIGNATURE	16				/		



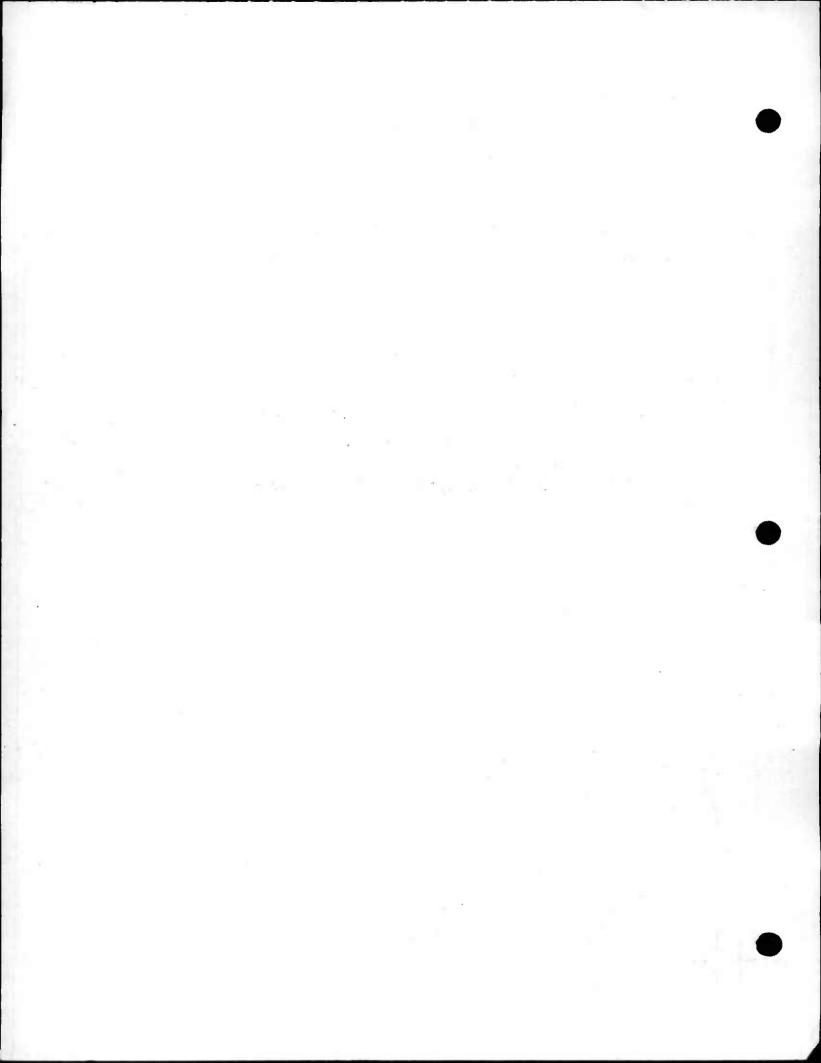
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8760	urted within
2 P	P BXPC
.O. BOX 68760	law requires that the death certificate be executed
-	death
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S H L L L	reduires
VII AL RECORDS,	h
7	PITAL OR ATTENDING PHYSICIAN: 1
DIVISION OF	ATTENDING
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	PITA

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEF	PARTMENT OF	HEALTH AND	MENTAL HYG					
		1. DECEDENT'S NAME (First, Middle, Last) DORIS L.	McDANIE	Ĺ			2. DATE OF DEAT	TH DAY 995	YEAR	3. TIME OF DEATH		
 MARYLAND Z1Z13-0020 Refained by the hospital or attending physician. Should be detached for use as the burial-transit permit. Pages 1, 2, 3 should a notified at once. 		4. SOCIAL SECURITY NUMBER 214-24-4933	1 □ M 2 🔀 F 75	(In yrs. last birtho	S. MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Ye May 23,	ar)	Country)	PLACE (State or Foreign Cimore, Md.		
		9a. FACILITY NAME (If not institution, give st Mercy Hospice RESIDENCE OF DECEDENT	reet and number)		96. CITY, TOWN	OR LOCATION OF D	DEATH		IMOTE (
		10a. STATE 10b. COUNTY	ford	10c.	CITY, TOWN OR LOC					10d. INSIDE CITY LIMITS? 1 YES 2XXNO		
		10%. STREET AND NUMBER 2141 Glencove Ro	of, ZIP CODE 21034	10g. CITIZEN OF WHAT COUNTR								
		11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	If yes, s	PECENDENT OF HISPA Appecify Cuben, Mexic S 2 NO Speci	y Yea or No-	Yea or No- 14. RACE — American Ind Black, White, etc. Specify: White				
		15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	(Give kind life. Do NO	IT'S USUAL OCCUPAT of work done during in IT use retired.)	nost of working		F BUSINESS/IND	DUSTRY	100		
		17. FATHER'S NAME (First, Middle, Last) Eugene Miller		WIFI	ng & Sold	18. MOTHER'S N	Manu AME (First, Middle, Me Johnson	factur:	ıng			
	TO B	19a. INFORMANT'S NAME (Type/Print) Mrs. Carol Chessi	er	19b. MAIL 3547	ING ADDRESS (Street	end Number or Rural	Baltimo	r Town. State, Zip	^{Code)} 2123	6		
Page 6 may be I director, page a		20a, METHOD OF DISPOSITION 1 \(\overline{D}\) Burlal 2 \(\overline{D}\) Cremation 3 \(\overline{D}\) Remote 4 \(\overline{D}\) Donation 5 \(\overline{D}\) Other (Specify)	Mo	o.PLACEANDDA netery, crematory, Oreland	or other place) Mem.Park	Name of July 28	1	Baltimo				
r death. Pag re funeral di al.		21. SIGNATURE OF FUNERAL SERVICE LICE	assah	\mathcal{L}	E. F		r Funeral Md. 21087					
HOSPITAL OR ATTENDIAGE. THE COLLEGE AND A COLLEGE AND A COLLEGE AND A COLLEGE AND A COLLEGE AND A COLLEGE AND A COLLEGE AND A COLLEGE AND A COMPLETE, NOUR SHEE death. Page 6 mit THERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. TANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must		23. PART I. Entar the diseases, or contained the second three thre	ist only one cause on s	tatic	Lung	Ode of dying, aud	ch ss csrdiac or r	espiratory srr	ast,	Approximata Interval Batwean Onsat and Daath		
	8	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A							300		
		PART II. Other significant conditions	Osteopo	0-0875			PEI	S AN AUTOPSY REFORMED?	0	WERE AUTOPSY FINDINGS WAAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
	SICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF E	OTHER:		N 🗓		<u> </u>			
	РНУ	1 O YES 2 NO 27. MANNER OF DEATH 1 Netural 5 O Pending	1 Inpatient 2 ER/Outs 28a. DATE OF INJURY (Month, Day, Year)		A 4 Nursing Ho TIME OF 28c. IN INJURY	me 5 Residence	Other (Specify) 28d. DESCRIBE H		URED			
	ETED BY	Accident investigation Accident investigation	Suicide 8 Could not be building, etc. (Specify)						281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
	COMPLE		IAN: To the best of my know							end menner es stated.		
TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: If	O BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	Memo u	9		29c. LICENSE NU		29d. DATE	E SIGNED (A	Month, Day, Year) 26,1995		
, [F	30. NAME AND ADDRESS OF PERSON WHO DR. FERNANDO FER	COMPLETED CAUSE OF DE RRO 5810 BE	LAIR RO	ype, Print) DAD BALT.	IMORE, MI	D 21206			1.,,,,		



FOR STATE REGISTRAR	STAT	E OF MARYLA	ND / DEPARTMENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.
1. DECEDENT'S NAME (Firs	I, Middle, Last)			2. DATE OF DEATH
	GERTRUDE	DAMEREL	NORDLING	JULY 28 19

					JETT III	TOATE		DLA		REG.	NO.		
	1	1. DECEDENT'S NAME (First, Middle, La								2. DATE OF DEATH	DAY	YEAR	3. TIME OF DEATH
				EREL N	ORDLI	NG			_	July 28		1 6 7 1	10:35P M
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Yea	r)	8. BIRTH	IPLACE (State or Foreign
P		214-40-3880	1 □ M 2 X X F	90	YRS.	MONTHS	UATS	HOURS	Service.	November 4			ryland
plnovs	-	9e. FACILITY NAME (If not institution, give				9b. CITY,	TOWN (OR LOCATI	ON OF DE			INTY OF D	
2, 3		Asbury Methodis	t Home				Gai	thers	sbur	g	1	Mont.c	nomerv
1,	[2]	RESIDENCE OF DECEDENT 10a, STATE 10b, COU	NTY		I 100 CI	Y, TOWN O	B LOCAT	TION				10110	
Pag	DIRECTOR	Maryland M	lont company		100.01								10d. INSIDE CITY LIMITS?
permit. Pages	AL C	10a, STREET AND NUMBER	lontgomery			Gait	<u>ner</u>	sburg]		Lie en		1 TES 2 WHO
St.	1 %	403 Russell Avenue								WHAT COUNTRY?			
020 physician. bunial-transit	FUN	11. MARITAL STATUS 12. WAS DECEDENT EVER IN			N U.S. ARMED 13. WAS DECENDENT OF HISPANI				USA_				
020 physician. burial-trar		1 Never Married 2 Married FORCES? 1 YES 2			2 YNO If yes, specify Cuban, Mexican, Pt			, Puerto Rican, etc.) Blec			E — American Indian, k, White, etc.		
215-0 attending se as the	BY	¾(X) Widowed 4 □ Divorced		out on oateo		1 ☐ YES ZYNO Specify: Specify:					White		
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2 분 2	19	Elementery/Secondery (0-12)	College (1-4 or 5		life. Do NOT u	se retired.)	iui g mo	SI UI WUTAN	NV				
AND 2 the hospital detached for	COMPL		4		Teacl	ner				Balto	City	Dept	of Education
Q 9 9	WOS	17. FATHER'S NAME (First, Middle, Last)						18. MOTI	HER'S NA	ME (First, Middle, Mai	den Surname)		
	BE	Edward Waller	Damerel					Ge	ertri	ude Smith			
MAR retained 5 should	2	19a. INFORMANT'S NAME (Type/Print)						nd Number	or Rural I	Poute Number, City or	Town, State, Zij		
- 2 2		Mary Katherine	Sheeler		<u>714 Ea</u>	ast S	emir	nary	Aver	nue Towso	n. Mar	vlan	d 21286
6 may		20e. METHOD OF DISPOSITION 1 X Furlal 2 Cremation 3 R	emoval from Stata	20b. PLAC	E AND DATE	OF DISPOSI	TION (Ne	me of		DATE 20c.	LOCATION -	Cify or To	wn, State
		4 Conation 5 Other (Specify)	· · · · · · · · · · · · · · · · · · ·	Parki	WOOD (В	altimo	re.	Maryland
death. Pa		27 Journal Of Funeral Service	DCENSEE	K.	1)	22. 9	NAME AN	D ADDRES		CILITY			
BALT frer death. the funera		Mitchell-Wiedefeld Home 6500 York Poad Baltimore, Manyland 24040											
hours after ed in by the or remova		23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate											
hour led in		ahock, or heert failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final											
ety fill		disease or condition resulting in death)	Ala	10 - :		*	,	0	- /	fast			Officer and Death
ompletely of crema		resulting in death)	DUE TO	(OR AS A CONS	SEOUENCE O	F):				tast			YEAR
		Vacabana and a superior	b.										1/
OX 68 be execut ciclan and ciclan to burit	ERTIFICATION	Sequentially list conditiona, if any, leading to immediate	DUE TO	(OR AS A CONS	EOUENCE O	F):							
thysical prices	2	cause. Enter UNDERLYING CAUSE (Disease or injury	c										
Sertifical ling phy spiene p	붙	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONS	EOUENCE O	F):							
death certificate attending physiene pri	CER	d											
	ب	PART ii. Other algnificant conditi	one contributing to	deeth but no	t resulting	in the und	deriying	g cause g	lven in	Part i. 24a, WAS	AN AUTOPSY	24b.	WERE AUTOPSY FINDINGS
T # D # 3	MEDICAL	Antmin								PER	ORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
requires the	B	Atrial	Fibr	: 11 -	4: 1	10				1 U YES	2 NO		OF DEATH?
e law requals been Dept. of		DID TOBACCO USE CON					ЮГ	LINC	ERTAIN	J Or			1 TES 2 NO
AL he law he law be Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL			ACE OF DEAT			0140	EKIAII	<u> </u>			
SICIAN: The certificate h	Sic	EXAMINER?	HOSPITAL:	ER/Outpatient	3 DOA	OTHER	: Ina Hom	5 Ba	eldence	6 Other (Specify)			
rSicial ricertification in the	. i 🛨	27. MANNER OF DEATH	28s. DATE OF	INJURY	28b. TIM	E OF	28c. INJI	JRY AT	- I	28d. DESCRIBE HO	W INJURY OC	CURED	
NG PHYS frer this c	ВУБ	1 Natural 5 Pending 2 Accident Investigation	(Month, D	ay, rear)	INJ	URY M	1 🗌 Y	RK? 'ES 2 [NO [
NDING NDING IT death		3 Suicide 6 Could not b	28e. PLACE O	F INJURY At I	home, farm, s	street, tecto	ry, office			281, LOCATION (Stre	et and Number	or Rural R	oute Number,
OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has both hours after death with the State Dept. Item 28 is marked or them 28.	'	4 Homicide datarmined		ote: (opcomy)						City or Town, St	are)		
	PLE	29a. CERTIFIER (Check only	SICIAN: To the best of	my knowledge,	death occum	ed et the tir	ne, date	end place.	end due	to the cause(e) end	manner ee etel	ad last	
HOSPITAL FUNERAL WITHIN 72 I													end manner ee atated.
THE HOSPI THE FUNE filed within	Ö	29b. SIGNATURE AND TITLE OF CERTIF						29c. LICE					(Month, Day, Yeer)
五五		Musta	21	des				03	18	3 1	290. DAI	ESIGNED	(Month, Day, Yeer)
223	2	30. NAME AND ADDRESS OF PURSON Y	VHO COMPLETED CAUS	SE OF DEATH (IT	EM 27) (Type.	Print)	1 . 1	- 1		+ 100.	1	MIX	01/179
1		Christoll	1	0.	1	. /	011	1.	- 60	it mo-	720	04 0	y Ave
(0		31. DATE FILED (Month, Day, Youn)	32 AEGISTRA	R'S SIGNATURE	100	0	11 () ((V,	115/	N GD	2	0100
		AUG 0 1 199	5 Julian	luctorie	Wall.								j



		1 - FOR STATE REGISTRAR	ATE OF MARYLAND) / DEPAR	RTMENT	OF HE	ALTH A	ND ME	NTAL HYGIEI			
		1. DECEDENT'S NAME (First, Middle, Last) Nellie Sopt						2.	DATE OF DEATH	DAY	YEAR	S. TIME OF DEATH
Ð		H I	M 2 XF -90	lest birthday) 789 YRS.	# UNDER 1		IF UNDER 24	MIN,	DATE OF BIRTH (Month, Day, Year)		8. BIRTHPI Country)	
, 2, 3 should	TOR	99. FACILITY NAME (If not institution, give street and Greater Balto. Medi		- 6		VSON		OF DEATH	1		TY OF DEA	
permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY MARYLAND BALTIM	IORE		Y, TOWN OR	I.	MONIU	М			- 1	IOd. INSIDE CITY LIMITS?
- SE	FUNERAL	100. STREET AND NUMBER 108 Northwood				101. 2	2109	93		10g. CITIZ US.		IAT COUNTRY?
21215-0020 al or attending physician. for use as the burlal-transit	₽	1 Never Married 2 W Married FC	AS OECEDENT EVER IN U.S. PRCES? 1 TYES 2 YES, GIVE WAR OR DATES	ARMEO ANO	If y	yes, spec	NDENT OF Hy-Cuben,	Maxican, P	ORIGIN? (Specify Ya uarto Rican, etc.)	a or No—	14. RACE - Black, 1 Specify: WHI	
	COMPLETED	15. DECEDENT'S EOUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Colle 1	ed) ge (1-4 or 5+)	Give kind of the Do NOT us. Homema	work done dui se retired.)	UPATION ring most	of working		166. KIND OF BU			.111
2 2 2 1	iii 5	17. FATHER'S NAME (First, Middle, Last) John F. Cox 19a. INFORMANT'S NAME (Type/Print)					18. MOTHER'S NAME (First, Middle, Meiden Surmame) Elizabeth F. Thompson					
	2	93										
	evaluated lines the	20r. METHOD OF DISPOSITION 1 1 2	m Stale 20b. PLAG cometery, Dula	cramatory or o	thar place) 111ey 22. NA Le	Mem.	Gard ADDRESS n Fur	of facilities	JULY Ti	Du1a:	n. MD	21093 Valley,Inc.
	N N	23. PART I. Enter the diseases, or compile shock, or heart failure. List on iMMEDIATE CAUSE Plant disease or condition resulting in death)	Bouged to Our To Our To Our To Our To Our As A CON	Per	fora	lia oli	of dying	, such as	s cerdiec or reep	elratory arre	st,	Approximete Interval Between Onset and Death BOHMS
P.O. BOX	5 15	Sequentially liet conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
requires that the sen signed by the of Health and M	MEDIC	PART II. Other eignificent conditions control DID TOBACCO USE CONTRIBUT						en in Pari	PERFO	RMED?	Of Oil	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO
SICIAN: The law certificate has be the State Dept.	SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOS		LACE OF OEAT	OTHER:	y one)			Other (Specify)			
DING PHYSICIA After this certification death with the	ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	Ba. DATE OF INJURY (Month, Day, Year)	28b. TIM INJ	E OF 28 URY	Bc. INJUR WORK	TA Y	280	J. DESCRIBE HOW	INJURY OCCU	IRED	
TTENDI STOR: A after de	ETED	4 Homicide detarmined	Be. PLACE OF INJURY — Al building, etc. (Specify)	home, farm, s	streel, factory	, office		261	LOCATION (Street City or Town, State		r Rural Roul	te Number,
보 기 기 기 기	_ ⊑	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: Te MEDICAL EXAMINER: On the										nd mennar as stated.
TO THE HOSPIT TO THE FUNERA De filed within 7	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO GOMP	NETED CHIEF OF DEATH (TEM OT CA	2:	2		3 4°		29d. DATE	SIGNED (M	fonth, pay, Year)
		Walter Hepner III,	M.D. 3346	Paper		L Rd	., Ja	ackso	nville,	Maryl	and	
		AUG 0 1 1995 AU	REGISTRAR'S SIGNATURE	lell								

FUNERAL

BY

COMPLETED

BE 9

CERTIFICATION

PHYSICIAN: MEDICAL

ВУ

COMPLETED

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AUG 01 1

permit. Pages 1, 2, 3 should the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. the attending physician and completely filled in by the funeral director, page 5 should be defacted for use as the burial-transit Mental Hygiene prior to burial, cremation, or removal. notified at once. pe must examiner the medical THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within THE FUNERAL DIRECTOR. After this certificate has been signed by the attending phycician and completely filed within 72 hours after death with the State Dept. of Health and Mental Hydiene prior in hurfal rewards injury, or other traumatic event, shows any 23 marked, or Item 69 item 28 TO THE FUNERAL D be filed within 72 hc IMPORTANT: If in

Item1 8-1-95 FilmG726 W.H.Per F/H 23092 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Edward 1995 BERNARD OWENS JULY 1339 PM 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (in yrs. lest birthday) 7. DATE OF BIRTH (Morth, Day, Year IF UNDER 1 YEAR IF LINDER 24 MRS 8. BIRTHPLACE (State or Foreign YRS. Sec. 9a. FACILITY NAME (If not institution, give str 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ST. AGNES HOSPITAL E.R. BALTIMORE CITY 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY ryan MURE 1 VES 2 NO TREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9 SA 21229 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried 3 Wildowed 4 Divorced 16a, DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
||fe. Do NOT use retired.) 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) year CIQ 17, FATHER'S NAME (First, Middle, Last) 20a. METHOO OF DISPOSITION
Burlel 2 Cremetion 20b. PLACE AND DATE OF DISPOSITION (Name 3 🗆 R 4 Donation 5 Other (Specify) SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF 6 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such es cardiac or reapiratory arrest, Approximate ahock, or heart fellure. List only one cause on each line. Intervel Betwe IMMEDIATE CAUSE (Final Onset end Death disease or condition resulting in deeth) ATTHEROS CLEPOTIC CAPRIOVAS aum DISATASA OUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 10 NO OF DEATH? JUROUTION 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | XER/Outpatient 3 | DOA OTHER: 1 X YES 2 | NO 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO Investigation 2 Accident 28e. PLACE OF INJURY — At home, term, street, tectory, office building, atc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) and menner ee stated. 3/ MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occured at the time, data and piecs, and due to the cause(e) and manner se stated. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

O.C.M.E

A-KORSL NWO 111 Penn Street, Baltimore, Maryland 21201 37. REGISTHAR'S SIGNATURE

AND ADDRESS OF PERSON, WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

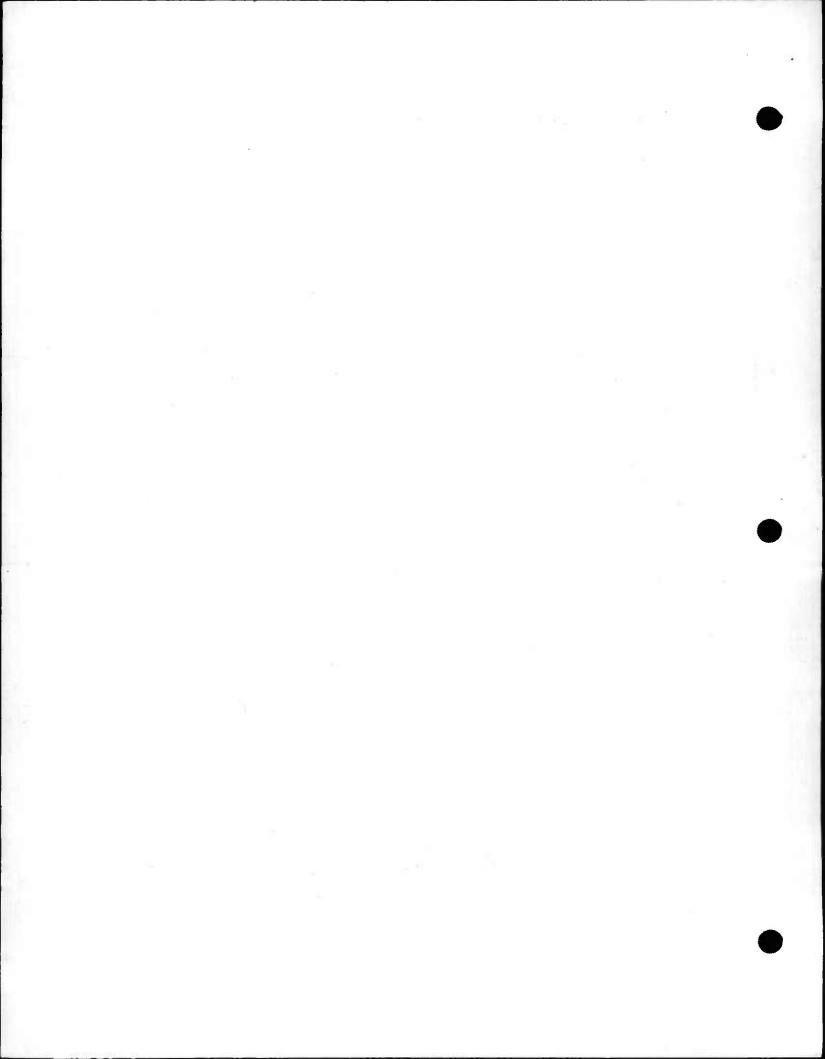
▶ JULY 26,1995

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	8
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	HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be

		ERNEST CI:		OREA		IF UNDER 1 YEA	R IF UNDER 24	JUZ		8 19	95	8:00 A
P		219-42-5987	1 M 2 - F	51		MONTHS DAY			b. 21, 19	943 K	Country)	ville, Md.
2, 3 should	TOR	98. FACILITY NAME (If not institution, give s Fallston General RESIDENCE OF DECEDENT				9ь. сяту, тоw Fall	N OR LOCATION STON			9c. COUNT	ford	N
21215-0020 all or attending physician. for use as the burial-transit permit. Pages 1,	DIRECTOR	Maryland Hari				est Hi						d. INSIDE CITY LIMITS? YES 2 X NO
sit perm	RAL	100. STREET AND NUMBER 801 Walters Mill	Road				101. ZIP CODE 21050	3		10g. CITIZEN OF WHAT COUNTRY?		
.0020 ng physician. he burial-tran	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 XXMarried 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 IF YES, GIVE WAR	YES 2 X	RMED NO	If yes,	ECENDENT OF specify Cuban,	NISPANIC ORIGIN Maxican, Puerto Specify:	i? (Specify Yea Rican, etc.)	<u> </u>		American Indian, hite, atc.
r attendli		15. DECEDENT'S EDUI (Specify only highest grade	CATION completed)	16a. DE	ECEDENT'S L	USUAL OCCUP! ork done during o retired.)	TION most of working	16b	. KIND OF BUS	BINESS/INDUS		<u> </u>
AND 21 he hospital or detached for once.	COMPLET	Elementary/Secondary (0-12) 8th.	College (1-4 or 5+)				nt Fin				afer	& Sons
	BE CO	17. FATHER'S NAME (First, Middle, Last) John Raymond Orer 190. INFORMANT'S NAME (Type/Print)	n				Mai	rtha Upo	dike			
6 may be retained to the page 5 should tust be notified	5	Angela E. Orem			196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 801 Walters Mill Road Forest Hill, Md							1050
MOKE age 6 may director, pa		20a. METNOD OF DISPOSITION 1 💢 Burial 2 🗆 Cremation 3 🗆 Rame 4 🗆 Donation S 🗆 Other (Specify)	oval from State	BeTA1	ANDDATEO	FDISPOSITION Der pleca) Orlal	Grds. 7	7/21/95		cation — cr 1Air, M		Stata
SALIIN r death. Pag te funeral dir al. examiner		21. SIGNATURE OF FUNERAL SERVICE LIC	essalv		_	E.	F. Lass	sahn Fui	neral k	Home	о M	d.21087
of the		23. PART I. Enter the diseasea, or cahock, or heert failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one ceuse Ventrica DUE TO (OR	on each line		ot enter the s	node of dylng					Approximete interval Between Onset and Death
ocertificate be execunding physician and Hygiene prior to burn or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST	JSCHEM DUE TO (OR CORDNAR DUE TO (OR	ic (ARd	io M	YOPA.	thy				2 YEAR 6 YEAR
Le law requires that the death has been signed by the atte Dept. of Health and Mertal 23 shows any injury,	N: MEDICAL	PART II. Other significant condition. SEVERE CHANIC OL SENA FAILURE, DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL	BI VENTRIC	PULMI ULAR E OF DEA	FAIL TH YES	y Dis	UNCE		24s. WAS AN A PERFORE 1 YES 2	MED?	AWA COI DF	RE AUTOPSY FINDINGS NLABLE PRIOR TO MPLETION DF CAUSE DEATH? YES 2 7 NO
SICIAN: The law certificate has the State Dep 1, or Item 23	YSICIAI	EXAMINER? 1 VES 2 DAO	HOSPITAL:		_	OTHER:		lence 8 🗆 Othe	r (Specify)			
PHY this with with	ву рну	27. MANNER OF OEATN 1 Acturel 5 Pending 2 Accident Investigation	28a. DATE OF INJI (Month, Day, Y		28b. TIME INJU	RY	NJURY AT WORK? YES 2		CRIBE NOW IN	JURY OCCUP	ΙΕΟ	
OR ATTENDING DIRECTOR: After hours after death	<u>a</u>	3 Suicide 6 Could not be determined	26a. PLACE OF IN- building, etc.	JURY — At ha (Specify)	me, farm, st	reet, factory, of	fice	28f. LOC. City	ATION (Street as or Town, State)	nd Number or	Rurel Route	Number,
로 되고 보	COMPLET		R: On the beat of my									d manner as stated.
TO THE HOSP! TO THE FUNEF DE filed within	TO BE	296. SIGNATURE AND THE OF CENTIFIER	Maler	di	2		29c. LICENS	SE NUMBER	/	29d. DATE S	IGNED (Moi	nth, Day, Year)
16	-	VIJAY S NAIR	M. O.	F DEATH (ITE		Print) Fin R	d. F	-Allsto	N MC	1 21	104-	7
10		AUG 0 1 1995	A RESIDENCE	SIGNATURE								

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

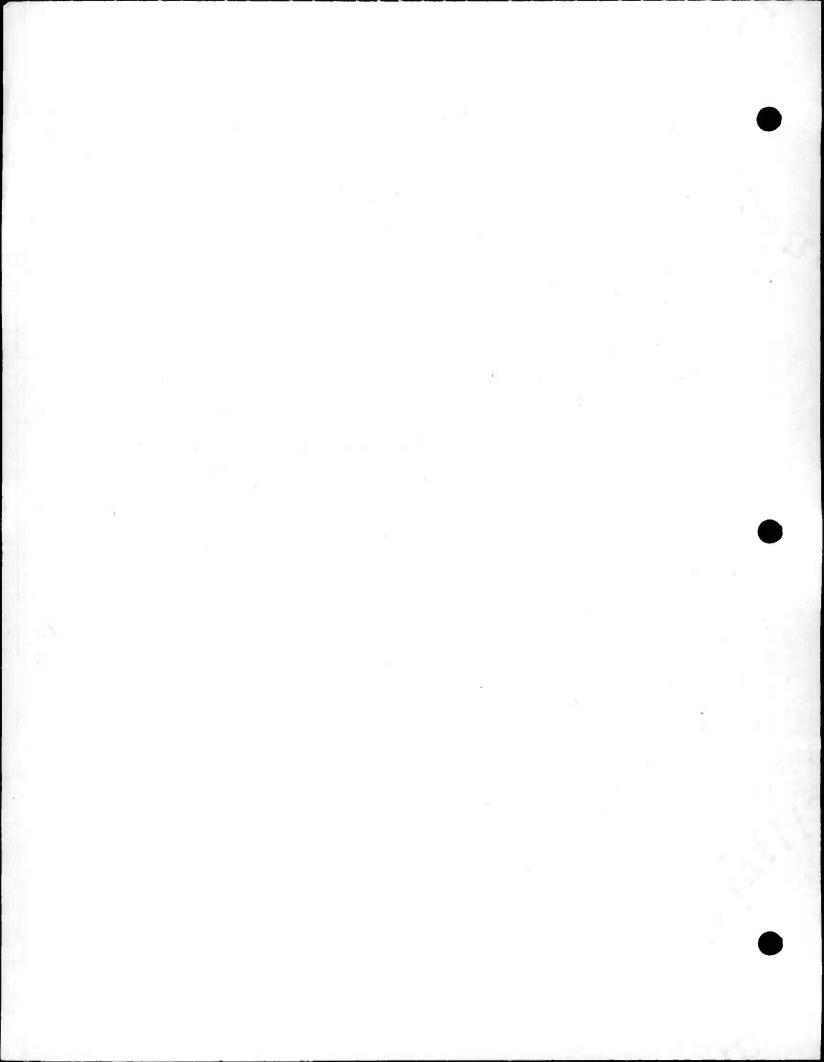


ITEMS: 20b,20c, PER F.H. FILM G-726 B/1/95 t.t

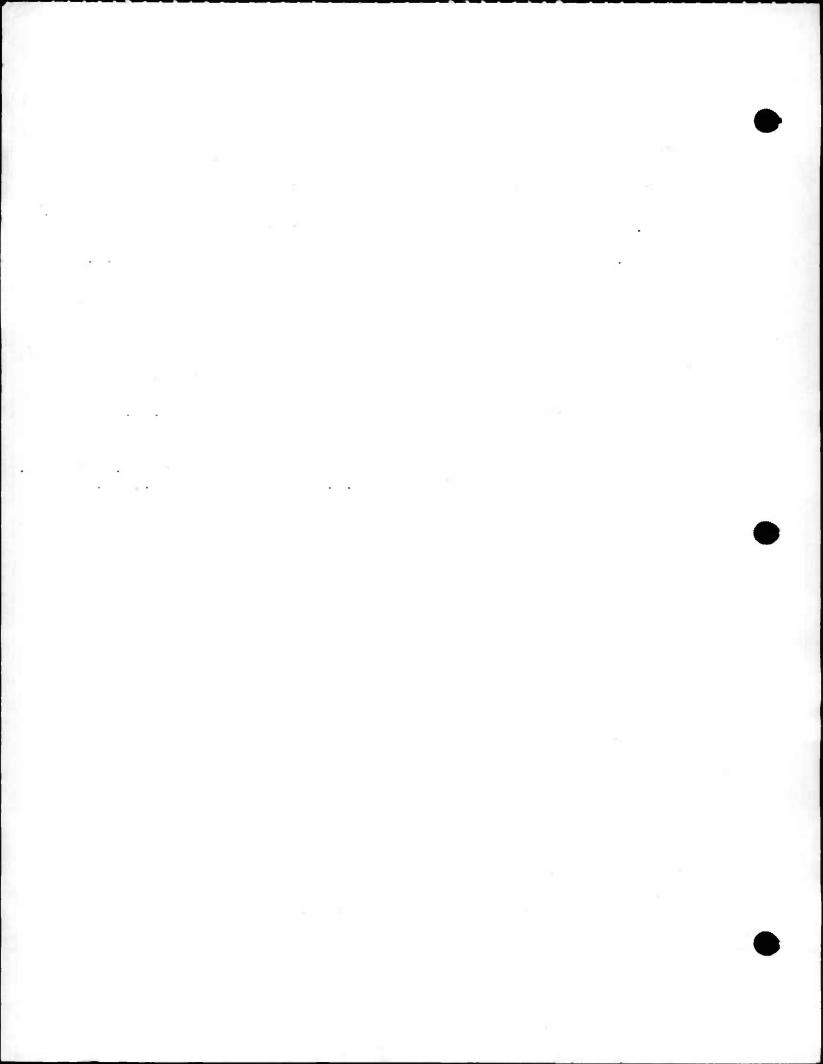
		1 - STATE REGISTRAR	SIAIE UF I	MANTL					DEAT		MENTAL	. HYGIEN REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, La	st)								2. DATE	OF DEATH		2	3. TIME OF DEATN
		LEDA	HANNA			PE	TTIG	REW			JUL	Y 27,	1995	YEAR	10:25A M
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE	(In yrs. last bir	rthday)	IF UNDER		IF UNDER		7. DATE	OF BIRTN Day, Year)		8. BIRTHP	LACE (State or Foreign
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pinous	CTOR	9e. FACILITY NAME (If not institution, give	e street end number)				9b. CITY	, TOWN C	OR LOCATI	ON OF DE				NTY OF DE	
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Jes 1.	łШ	10a. STATE 10b. COU	NTY			Oc. CIT	Y, TOWN	OR LOCAT	ION					1	10d. INSIDE CITY
permit. Pages	DIR	Maryland A	nne Arunde	21		Linthicum Heights									LIMITS?
permi	AL.	10e. STREET AND NUMBER						_	. ZIP CODE				10g. CITI		AT COUNTRY?
150	FUNERAL	404 Laura Ave	nue						210	90			ט ו	.S.A.	
020 physician. burial-transit	Ę	11. MARITAL STATUS	12. WAS DECEDEN	T EVER II	N U.S. ARMED	D	13.	WAS DEC	ENDENT O	F HISPAN	IIC ORIGIN	C ORIGIN? (Specify Yee or No- 14. RAC , Puerto Rican, atc.)			- American Indian, White, etc.
The part of the pa	ВУ	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE V						2 1 NO	Specify		ican, atc.)		Specify:	:
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NO.	릴	, (0.12)	2 years		Tax	Tax Analyst Radio Ratings									
the hospital detached to once.	COMPLET	17. FATHER'S NAME (First, Middle, Last)					16. MOTE	IER'S NAI							
# 64 Z	BE	17. FATHER'S NAME (First, Middle, Last) JOSEPH H. A. Gelinas Hanna C. Spokesfield 199. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
retained 5 should notified	10	190. INFORMANT'S NAME (Type/Print)			19b. M	AILING	ADDRES	S (Street e	nd Number						
5 5		John Pettigre	₹		404	1 La	aura	Ave	nue	Li	nthic	um Hg	ts.,	Mary:	land 21090
2 2 2 4		20e. METNOD OF DISPOSITION 1 St Burlet 2 Cremation 3 Re	amovat from State	20b	LVER RE	DATE	OF DISPOS	ITION /Na	me of -C		DATE	20c. LO	CATION —	WESTER	LY, R.I.
age 6 m director,		4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	LIOTUOEE	_ _M	IVER BE	tow	n St	ave	Vete	ran	8/:	Mid	dlet	own,	Connecticul
ALLIN death. Pag funeral dii l. examiner		21. SIGNATURE OF FUNERAL SERVICE) ()						D ADDRES			neral	Home	D 7	
2 - 2 - 2		C. Kuha	I Don	n	e		40	001 1	Ritch	nie E	Twv.	Ra1t:	imore	L Md	. 21225
ours after d in by the or removal	3	23. PART i. Enter the diseases, of ahock, or heart failur	r complications the	t caused	d the death	. Do n	ot enter	the mo	da of dyl	ng, such	aa cerd	ec or reepl	retory err	eat,	Approximate
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madi, 1		disease or condition reaulting in death)		Clr						_					5 day
B 2 - 8					A CONSEQUE	NCE OF	F):								5 days
OA bor but be executed with ician and comple rior to bunal, cre- traumatic even	8	Sequentially list conditions, Due To (OR AS A CONSEQUENCE OF):										Sclays			
or han	RTIFICATION	ceuse. Enter UNDERLYING													
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	F	resulting in death) LAST	d,												
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	<u> </u>										-	1 TYES 2	ON)	D	OMPLETION OF CAUSE OF DEATN?
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SICIA certif	<u></u>	27. MANNER OF DEATH	28e. DATE OF	INJURY		86. TIMI	E OF	28c. INJU	URY AT	Bidence	6 Other	(Specify)	JURY OCC	URED	
NG PHYS fler this eath with	ВУ Р	1 Natural 5 Pending	(Month, D	lay, Ybar)		167	URY M		RK? 'ES 2	NO NO					
NDING F. After death		2 Accident Investigation 3 Suicide 6 Could not b	28e. PLACE O	F INJURY etc. (Spec	— At home,	term, a	treet, fect	ory, office)		28f. LOCA	TION (Street a	nd Number	or Rural Rou	ite Number,
OR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the Six Item 28 is marked, or it	COMPLETED	4 Nomicide determined	bullang,	etc. (Spec	сну)						City o	Town, State)			W 18-4-23
DIRE hours	21	29e. CERTIFIER 1 CERTIFYING PN	/SICIAN: To the best of	my knowl	ledge, death	occurre	d at the t	lme, date	end place.	end dua	to the caus	e(s) end man	per ee state	ıd.	
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	NO.	one) 2 MEDICAL EXAMI	NER: On the beals of a	xamination	n end/or inve	atigatio	n, In my o	pinion, de	eath occur	d at the t	time, date o	end place, end	due to the	ceuse(s) s	nd menner se ateted.
E FUN		29b. SIGNATURE AND TITLE OF CERTIF							29c. LICE						Aonth, Day, Year)
TO THE HOSPIT TO THE FUNERA DE filed within 7	BE	Brian F	BOLDE	E.N	mo	>							1	melan	27 1990
, ,	2	30. NAME AND ADDRESS OF PERSON	VNO COMPLETED CAUS	SE OF DE	ATN (ITEM 27) (Туре,	Print)		101	65	i- 8		- 0		21251
		Brign E	DUC DEN	W	10	7	Jun	~	PO B	οY	JH	k1 . C	00 0	316	St Bulhom
(4)	Ì	31. DATE FILED (Month, Day, Year)	32. REGISTRA	B'S SIGN	ATURE			-			1	1 40		- 1	
		AUG 0 1 1995	James aller	man-	MANUELL										

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		1 - STATE REGISTRAR	STATE OF MARY					DEAT		MENTAL HYG REG.			
		1. OFCEDENT'S NAME (First, Middle, Last)	BDita	00	L/7					2. DATE OF DEAT		YO'EUR 3	TIME OF DEATH
10		4. SOCIAL SECURITY NUMBER		(In yrs. las	t birthday)	IF UNDER		IF UNDER		7. DATE OF BIRTH (Month, Day, Yes			ACE (State or Foreign
pinous		219 42 1084 94 FACILITY NAME (If not institution, give		77	YRS.	MONTHS	DAYS	HOURS	MIN.	Nov. 23	, 1917		
2, 3 sh	OR	North An	indel Ho	Spi	tal	Sh. CITY	en	PR LOCATIO	MOT BE	10	96. 00	UNTY OF DEA	Frankel
Pages 1,	DIRECTOR	10a. STATE 10b. COUNT	тү		10c, CIT	Y, TOWN O	R LOCAT	ION				1	Od. INSIDE CITY
permit. P	AL DI	Maryland An	ne Arundel		Pā	sade							LIMITS?
#S	IERA	203 - 11th Str	eet				101.	211				U.S.A.	
5-0020 nding physician.	BY FUNER	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, OIVE WAR OR I	2 N		11	yes, spe		1, Mexicar	IC ORIGIN? (Specific, Puerto Ricen, etc.)			- American Indian, White, atc.
Se se	뎶	15. DECEDENT'S EDI (Specify only highest grad		16a. DE6	CEDENT'S	USUAL OC	CUPATIO	oN st of working	a	16b. KIND OF	BUSINESS/II	NDUSTRY	White
ND 2 hospital o ached for Ge.	COMPLET	Elementary/Secondary (0-12) N/A	Cotlege (1-4 or 5+)	mo.	rber	e retired.)					er Sh	_	
YLA by the be del	BE CC		Francesco Pi						Ser	ME (First, Middle, Ma afina Pi	itonzo		
ay be retained page 5 should be notified	2	19a. INFORMANT'S NAME (Type/Print) Frank Pitonzo		19b 20	MAILING 03 —	ADDRESS 11th	(Street at	reet	or Runal R	oute Number, City of Pasadena	Town, State, I	zip Code) Yland 2	21122
e 6 m rector.		20e. METHOD OF DISPOSITION 1				of Disposi ther place) matol						Ore, M	aryland
ALT death. funer		21. SIGNATURE OF FUNERAL STANICE U	GINSEE OF	9/	u	Ge	orge	D ADDRES E J. Ritch	Gond	e Funer Wy. Ba	al Hon	ne P.A.	
in by remo		23. PART I. Enter the diseases, or shock, or heart feilure.	complications that cause List only one cause on a	d tha dea	ath. Do r	ot anter	tha mod	de of dylr	ng, auch	as cardiac or n	espiratory a	irrest,	Approximate intervei Between
y fille		iMMEDIATE CAUSE (Final disease or condition resulting in death)	4	5e	PS	5							Onset and Death
Pa to la	_		DUE TO (OR AS	A CONSEO			re /	0	ha	brust	700		
be be cian lor t	ATIO	Sequentially list conditions, If any, leeding to immediate cause. Enter UNDERLYING SMall Bowel Obstruction DUE TO (OR AS A CONSEQUENCE OF):											
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	ME	Rena		ire	1 YES 2 NO								The same
4 9 E 0 E	SICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?			_	H (Check o		UNCE	RTAIN				
SiCIAN: The certificate the State , or item	HYSIG	1 WES 2 NO	HOSPITAL: 1 Impetient 2 ER/Out 28a. DATE OF INJURY	patient 3			ing Home	-	ildenca (Other (Specify)			
ATTENDING PHYSICIAN: ECTOR: After this certificals after death with the St. 28 is marked, or it	ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)			M		RK? ES 2	NO	28d. DESCRIBE HO	OW INJURY O	CCUREO	
OR ATTENDI OR ATTENDI DIRECTOR: A nours after di Item 28 is	ETED	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY building, atc. (Spe	Y — At hon	na, farm, s	treet, facto	ry, office			28f. LOCATION (Str City or Town, S	reet and Numb tate)	er or Rural Rou	te Number,
対対は	COMPLE		ICIAN: To the best of my know										nd manner as stated.
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If	BE C	29b. SIGNATURE AND TITLE OF CERTIFIE			>			29c. LICEN	NSE NUMI	BER		TE SIGNED (M	ALT - ALCOHOLO-SIII.
₽ ₽ ₽ ₹	5	30. NAME AND ADDRESS OF PERSON W	O COMPLETED CAUSE OF OR	ATH (ITEM	27) (Type,	Print)		L	7	2603	-	July	47,1995
3		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATUPE		<u>.</u>							
		AUG 0 1 199		er les	lath				_				

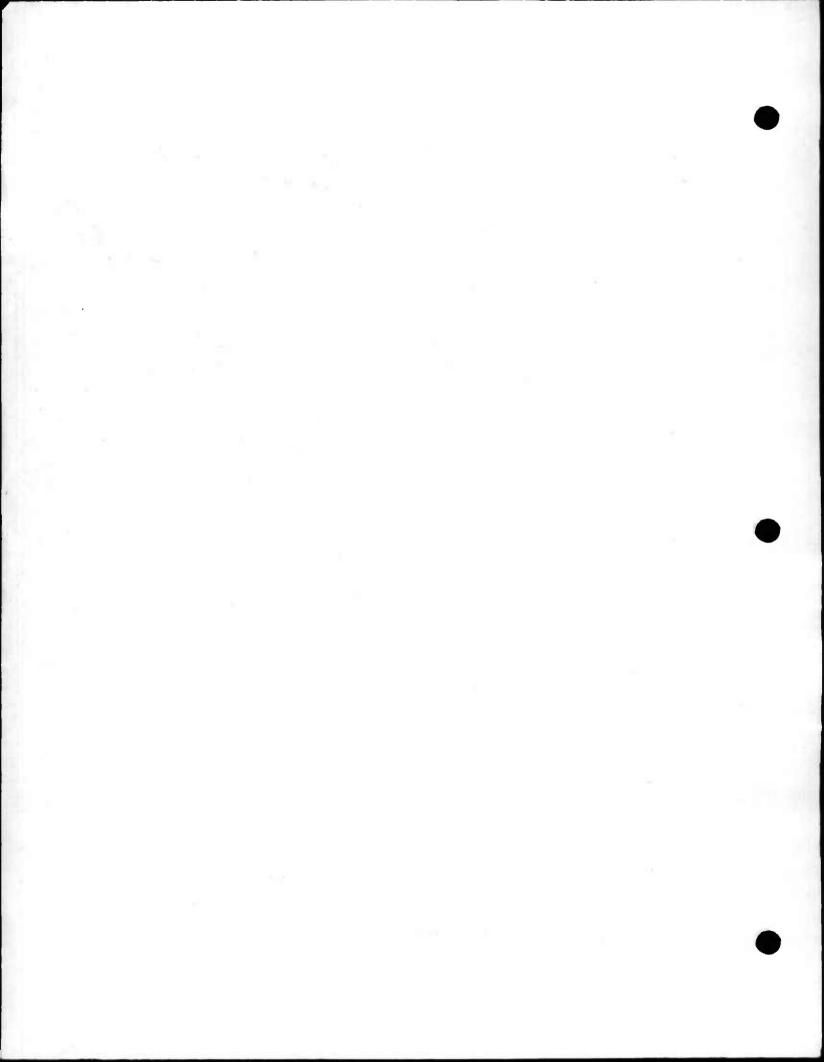


		1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTI	MENT OF H	EALTH AND	MENTAL HYGIEN					
		1. DECEDENT'S NAME (First, Middle, Last)	E. F	Price			2. DATE OF DEATH MONTH 7	6 95	3. TIME OF DEATH			
	9	4. SOCIAL SECURITY NUMBER 5	. SEX 6. AGE (1	n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	a. Bit	RTHPLACE (State or Foreign			
pino	OR	253-01-2917 1 9e. FACILITY NAME (# not institution, give stree		O YRS.		HS DAYS HOURS MIN. (Month, Day, Year) Gently Georgia						
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n. ansit pe	FUNERAL	11 W. 20th Str	eet		101	21218		U.S.				
21215-0020 al or attending physician. for use as the bunial-transit permit. Pages	B	11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Merried 3 ፟	P. WAS DECEDENT EVER IN FORCES? 1 2 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp		NIC ORIGIN? (Specify Yeon, Puerto Rican, atc.)	В	ACE — American Indian, lack, White, atc. pecify: Black			
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MARYI retained by 5 should be notified at) BE	19a. INFORMANT'S NAME (Type/Print)		and Number or Rural	Route Number, City or Tox	vn, State, Zip Code)						
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BALTIMORE, MARYLAND er death. Page 6 may be retained by the hospit the funeral director, page 5 should be detached val. examiner must be notifiled at once.		1 Buriel 2 Cremation 3 Ramova 4 Donation 5 Other (Specify)	from Stata Cerri	PLACE AND DATE OF etery, crematory or othe arrison F	r niacel		8-1-95 Ow	ings Mi				
ALTIMOR death. Page 6 ma e funeral director, p f.		21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE		22. NAME A	NO ADDRESS OF FA	172	L-27 N.	Monroe St.			
BALTIMORE, rs after death. Page 6 may be n by the funeral director, page removal. addical examiner must be in		Wortha ye							ID. 21217			
tely filled in the mation, or red		23. PART I. Enter the diseases, Dr cDn shock, or heart feliure. Lis IMMEDIATE CAUSE (Finel disease Dr condition resulting in death)	t only one ceuee on ee	ech line.			n aa cardiec or resp	Iratory erreet,	Approximate Interval Between Oneet and Death			
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٠ ج الله ج ١	ERT	resulting in death) LAST										
the d wer injur	CALC	PART ii. Other eignificent conditione of	ontributing to deeth bu	ut not reculting in	the underlying	g ceuse given in	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
CO res the signed signed signed	MEDIC						1 YES	NO	COMPLETION OF CAUSE OF DEATH?			
w req been been ot. of		DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF	F DEATH YES	□ NO □	UNCERTAI	N-EX		1 PES 2 NO			
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OF V PHYSICIAN this certifi with the thed, or	ЭНХ	27. MANNER OF DEATH	Inpatient 2 ER/Outpe 28a. DATE OF INJURY (Month, Day, Year)	28b. TIME C	OF 28c. INJ		8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCURED				
ON OD DING PHYS After this death with s marked	B≼	1 Natural 5 Pending 2 Accident Investigation	28a. PLACE OF INJURY		-M 1 🗆 1	YES 2 NO						
STOR: after	TED	3 Suicide 8 Could not be determined	building, etc. (Speci	fy)	et, factory, offic		28f. LOCATION (Street City or Town, State)	and Number or Hur.)	ti Houte Number,			
7 7 7	COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: (N: To the best of my knowled On the basis of examination						e(a) and manner es stated.			
TO THE HOSPITA TO THE FUNERA De filed within 72 IMPORTANT: I	BE	296 SIGNATURE AND TITLE OF CENTRIER	1			29c. LICENSE NUI	ABER	29d. DATE SIGN	ED (Month, Day, Year)			
₽ ₽ ₽ %	2	30 NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Pr	rint)	621	9	11/2	-6195			
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•		210 - 212	SEX 6. AGE (In yrs.		7	7. DATE OF BIRTH (Month, Day, Year)	6.	BIRTHPLACE (State or Foreign Country)
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s 1, 2, 3	DIRECTOR	HAR BOT HOS RESIDENCE OF DECEDENT 10s. STATE 10s. COUNTY	PILAL	Bak	to ma		N.	A
nit. Pager	1	Md N.A)	Balto	OCATION			10d. INSIDE CITY LIMITS? 1 1 YES 2 1 NO
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ending physician as the bunal-tra	B≺		. WAS DECEDENT EVER IN U.S.	□NO If yes	DECENDENT OF HISPAI I, specify Cuban, Mexico YES 2 NO Specifi		a or No— 14.	RACE — American Indian, Black, Whita, atc.
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के दे	BE	HOWARD 198. INFORMANT'S NAME (Type/Print)	PATTERSON	19b. MAILING ADDRESS (Str	MAbe	L BRO	win	
y be retained hage 5 should be notified	5	Joyce PAtter	SON S	819 CHAps	LGATE LI	ANE BAL	To- M	1 21229
ge 6 may irector, pa		20a, METHOD OF DISPOSITION THE Burlet 2 Cremation 3 Removal 4 Donation 5 Other (Specify)		CE AND DATE OF DISPOSITION OPERATORY OF OTHER PLACES	Forest	8/3 O		or Town, State MILLS. Md
ter death. Page 6 may be the funeral director, page yal.		21. MO LATURE OF FUNERAL SERVICE LICENS	ella - J	22. NAM	AND ADDRESS OF FA	al Home	1304	n Centrals
hours af od in by or reme		23. PART I. Enter the diseases, or come chock, or heart failure. List IMMEDIATE CAUSE (Finel	plications that caused the complete prications that caused the complete pricat	death. Do not enter the ne.	mode of dying, suc	h es cerdiec or reep	iratory arrest,	Interval Between
nted within 24 ho completely filled ial, cremation, or event, the m		disease or condition resulting in death)		TIC CARO	INOMA (OF Col	ON	74ears
executed w and comp o burial, cr	N N	Sequentially list conditions,	GANGREN	IE OF R	IGHT L	-ea		25 days
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certif ding Hygier	CERTIFICATION	thet initieted events resulting in deeth) LAST	DUE TO (OR AS A CONS	EOUENCE OF):		1, 4, 5		
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SICIAN: The certificate han the State D	PHYSICIAN:		26. PL/ OSPITAL: Opportent 2 - ER/Outpetient	ACE OF DEATH (Check only of OTHER:	ne) forne 5 🗆 Residenca	a [] Dehar (Snarihi)		
this with		27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 28c.	INJURY AT WORK?	28d, DESCRIBE HOW I	NJURY OCCURE	êD
ENDING PRESENT SET OF THE PRESENT OF	р ву	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY — At It building, atc. (Specify)		YES 2 NO	281, LOCATION (Street City or Town, State)	and Number or R	lural Route Number,
DIRI DOIN Tem	LETE	4 Homicide detarmined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN				4010		
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4		31. DATE FILED (MONTH, Day, YOU)	APBOL HOSP:	CENTER BOO	1 S. HANOVE	ER ST. BA	LTIMOR	G MD&1225



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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95 23098 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR GEORGE WILLIAM 10:30 POTEET A. M SR. JULY 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 💟 M 2 🗌 F 220-14-8707 68 AUG MARYLAND 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 500 MANOR ROAD GLEN BURNIE ANNE ARUNDEL RESIDENCE OF DECEDENT 10a STATE 10b. CDUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ANNE ARUNDEL GLEN BURNIE 1 YES 2 X NO FUNERAL 10a STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 500 MANOR ROAD 21061 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE — American Indian, Black, Whita, atc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 1 Never Married 2 X Married IF YES, GIVE WAR OR DATES BY Specify: 3 Wildowed 4 Divorced WWII WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ast of working Elementary/Secondary (0-12) College (1-4 or 5+) MOUNTAINSIDE TRANSPORT TRUCK DRIVER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) JEROME В. POTEET, JR. BE MARIE LEWIS 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 GEORGE W. POTEET, JR. 351 DOGWOOD ROAD, MILLERSVILLE, MD 21108 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata 1 M Buriel 2 Cremation 3 Removal from State cemetery, cremetory or other place)
GLEN HAVEN MEMORIAL PARK 4 Donation 5 Other (Specify) 18/2 GLEN BURNIE, MD 21. SIGNATURE OR'S 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such sa cerdiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervei Between IMMEDIATE CAUSE (Final **Onset and Death** d der disease or contlition resulting in death) æ Cancer CIURN CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 26. PLACE DF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER HOSPITAL: 1 YES 2 NO OTHER: ☐ Inpatiant 2 ☐ ER/Outpatient 5 Residence 8 Other (Specify) 4 Nursing Home 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending М 1 YES 2 NO ВУ 28a. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 9 8 Could not be 4 Homicide datarmined Щ 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. COMP (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 027838

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	ertificate be executed within 24 hours after death. Page 6 may h
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Pages 1, 2, 3 should permit. burial-transit the SE USe ĮQ. detached once. 2 notified at 5 should pe must examiner funeral filled in by the medical ŏ cremation, the and completely fi to burial, cremation traumatic event, prior to t 6 any certificate has been signed h the State Dept. of Health a Dept. LL DIRECTOR: After this certificate 2 hours after death with the State 1 tem 28 is marked, or iter FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

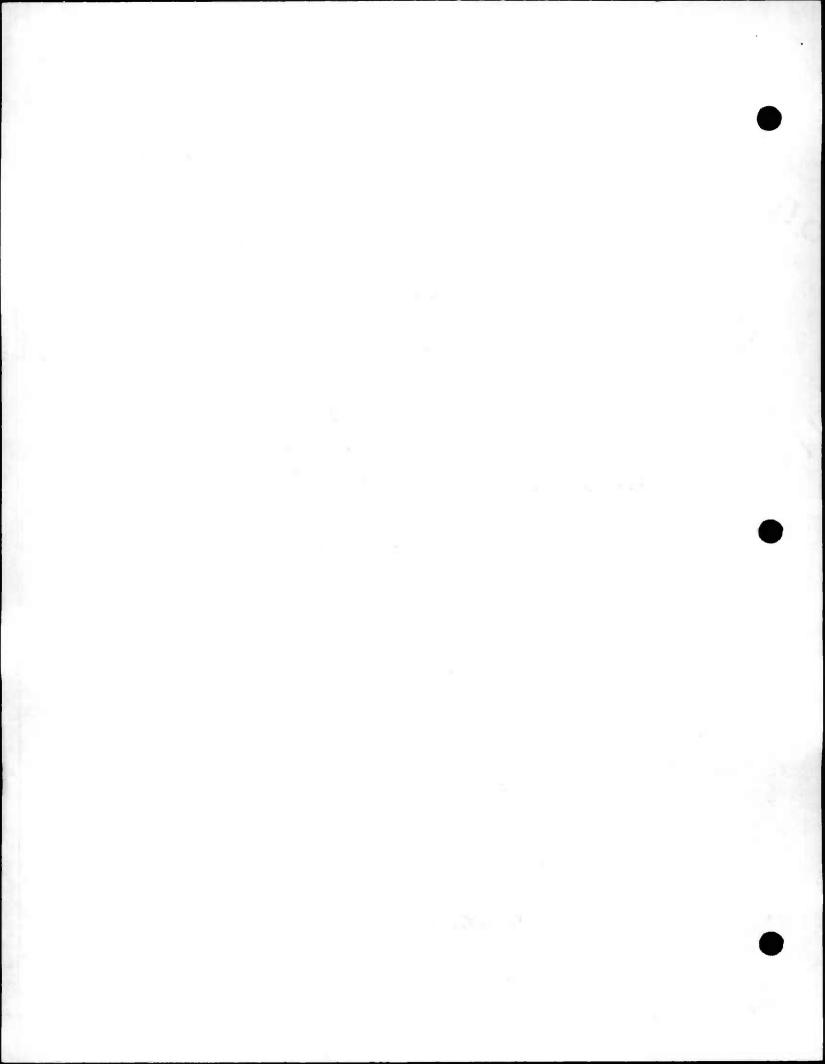
1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DONALD WINFORD PURCELL July 23, 1995 12:15 ам 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH NOVEMBER 30, 1926 IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 218-22-5394 1XX M 2 | F DAYS HOURS BARRA BALTIMORE CO., MD. 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1705 OLD MILL LANE SALTSBURY WICOMICO RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY MARYLAND MICOMICO SALISBURY 1 TYES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 21801 10g. CITIZEN OF WHAT COUNTRY? 1705 OLD MILL LANE USA 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married WAFIES & KOREAN CONFLICT BY Specify WHITE 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4) or 5+) SALES MANAGER CHESAPEAKE CADILLAC 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) MERTON WINFORD PURCELL BEATRICE MATHRAS BE 19a. INFORMANT'S NAME (Type/Print)
JOAN L. PURCELL 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1705 OLD MILL LANE SALISBURY, MARYLAND 21801 20x METHOD OF DISPOSITION
1 D Burlat 2 Cremation 3 Removat from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State GARRISON POREST VA. CEMETERY JULY 27,1995 OWINGS MILLS, MARYLAND 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY LASSAHN FUNERAL HOME TNC abotton 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death disease or condition MOTASTATIC COLON CANCER ZYEARS resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resuiting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS OSTED ARTHRITIS AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO I UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: **EXAMINER?** OTHER: 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY Investigation 2 Accident 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

2 IMEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) BE 0.3980 as 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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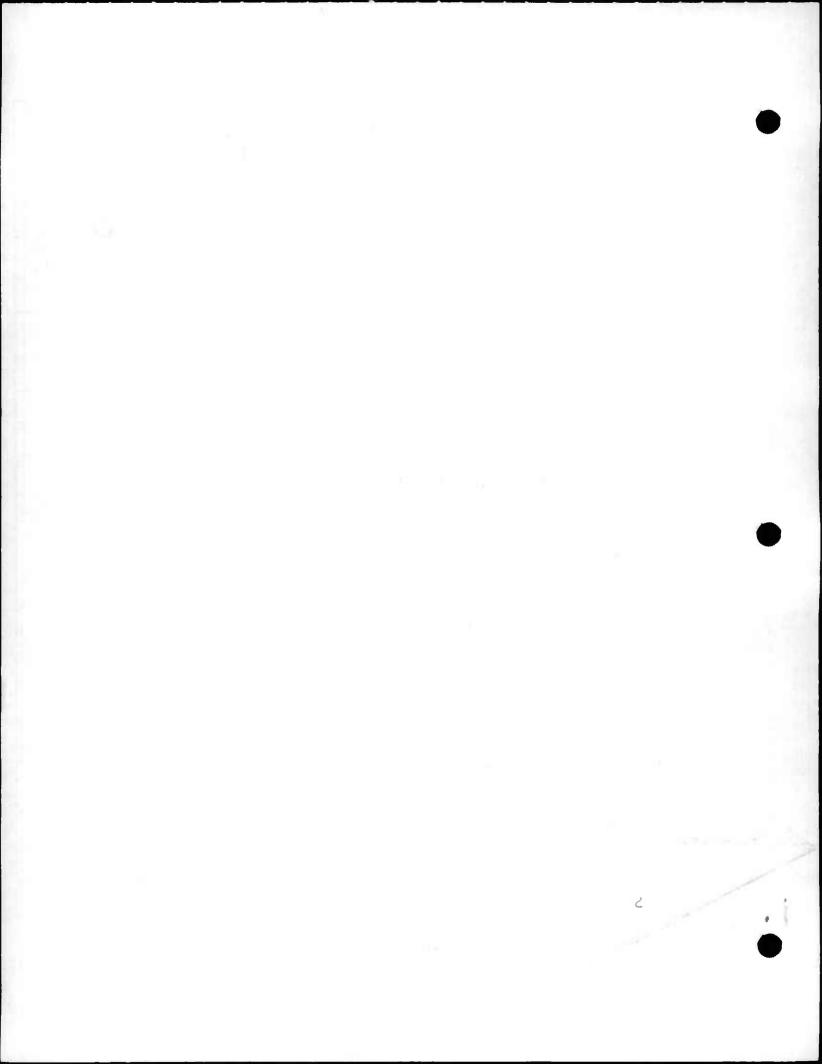
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FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN CARLTON JULY 28, 1995 ROBINSON 9:50 a M 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 212-26-1533 1 M 2 - F S.C. 6 1928 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF DEATH NIA DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT 10b. COUNTY 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY mills ma OWING permit. 1 YES 2 NO 10a. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 2111 and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to burial, cremation, or removal. Footlight U.S.A ane executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: **BALTIMORE, MARYLAND 21215-0020** 1 Never Married 2 Married Black, White, etc.
Specify: Black BY 3 Widowed 4 Divorced 3-4-52 Hay 12-9-57 COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18b. KIND OF BUSINESS/INDUSTRY entery/Secondary (0-12) College (1-4 or 5+) Petty officer Masker Chief U. S. Naul 17. NATHER'S NAME (First, Midgle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) eroy obinsin Washington notified at BE MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Owings mills, md 21117 Kobinson votlight Lone ě 20a METHOD OPDISPOSITION
1 Number of Cremetion 3 Removal from State
4 Departmen 5 Other (Specify) 20c. LOCATION - City or Town, State
OWINGS Mills, Md 20/ PLACE AND DATE OF DISPOSITION (Name of cematers, cremators or other place) must Vet examiner 22. NAME AND ADDRESS OF FACILITY
West 21. SIGNATURE OF FUNERAL SERVICE LICENSE nach ism Wabush medical 23. PART Librar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. **Approximate** intarvai Between IMMEDIATE/CAUSE (Final **Onset and Death** the disease or condition Metastatic Squamous Cen Lung Cencer DUE TO (OR AS A CONSEQUENCE OF): Metastatic resulting in death) 1 mo. event, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 9 been signed by the attending physician of, of Health and Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED?. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? cancer. Atrial fibrillation 1 TYES 2 NO shows a 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ${f f X}$ NO ${f \Box}$ UNCERTAIN ${f \Box}$ PHYSICIAN: has b Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate h EXAMINED? HOSPITAL: OTHER: 1 TES 2 NO ATTENDING PHYSICIAN: Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED this c marked, 1 Natural 5 Pending 1 YES 2 NO ₽ After 1 Investigation Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 Is COMPLETED 8 Could not be DIRECTOR:) determined Item 8 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated, TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 HOURSTANT: If It 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occursed at the time, date end piece, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year, lemo M.D. L5124 July 28, 1995 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. Danoff Johns Hopkins Hospital 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

							10/11		DLA		n	EG. NO.				
	1. DECEDENT'S NAME (FIRST		DERT								2. DATE OF D		8 1	995	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (II	in vrs. lesi	t birthday)	IF UNDE	1 1 YEAR	IF UNDER	R 24 HRS	7. DATE OF				IPLACE (State or Foreign	
	214-07-7777		1 □ M 2 🖳 🗗	82		YRS.	MONTHS	DAYS	HOURS		Aug. 2	8, 1	912	Count		
_	9a. FACILITY NAME (If not in		treet and number)				9b. CITY			ION OF DE	ATN		9c. COU	NTY OF D		
힏	Sinai Hospi						Baltimore							N/A		
낊	10a. STATE	10b. COUNTY	,			10c. CITY, TOWH OR LOCATION								10d, INSIDE CITY		
FUNERAL DIRECTOR	Md.	N	/A						altim	ore					LIMITS? 1 YES 2 XXNO	
RAI	10e. STREET AND NUMBER							101	. ZIP COD	_			_		VHAT COUNTRY?	
Ä	315 Inglesic	de Ave							212					U.S.	A	
5	1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	I YES	U.S. ARI	MED	13.	WAS DEC	ENDENT (OF HISPAN	IIC ORIGIN? (Sp	etc.)	or No-	14. RACE Black	American Indian, t, White, atc.	
BY	3 🔀 Widowed 4 🗆 Divo		IF YES, GIVE Y	MAR OR OA	TES				2 ⊠ NO			, ,		Speci		
COMPLETED	15. DEC (Specify only	EOENT'S EDUC y highest grade	CATION completed)		16a. DE0	CEDENT'S	USUAL O	CCUPATIO	ON ost of worki	200	16b, KIN	D OF BUS	SINESS/INE	DUSTRY		
Ш	Elementary/Secondary (0		College (1-4 or 5	+)	Ho.	Do NOT u	se retired.)		or or work	''y						
M P	12				НО	me M	laker		_		OW	n Ho	me			
8	17. FATHER'S NAME (First, M	iddle, Last)			T						ME (First, Middle				-1 1111	
BE	Harold				Jone					ara			zabe		Phillips	
2	Franklin Le										imore.					
20a. METNOD OF DISPOSITION																
1 [XBuriel 2 Cremetion 3 Removal from State Commetter, remetory or other (Specify) Meadowridge Cemetery 8/3/95 Jessup, Md.																
	21. SQUATURE OF FUNERA	r BENNICE-TIC	ENSEE	11		22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc.										
Ruck Towson Fune 1050 York Rd. To														4		
	23 PART Enter the di	seases, Dr c	omplications the	t causad	the dec	th. Do	not enter	the mo	de of dy	ing, suct	an cerdiec	or reepi	retory ari	rest,	Approximata	
	IMMEDIATE CAUSE (Fin		List only one cau												Interval Between Onset and Daeth	
Í	disease or condition resulting in death)	→ .	. URO	SE	PS	115										
}			DUE TO	(OR AS A	CONSEO	UENCE O	F):									
NO	Sequentially liet conditi	ons.	A						·- -			`				
CERTIFICATION	if any, leading to immediate. Enter UNDERLYI	diete	DUE 10	(OR AS A	CONSEO	UENCE O	F):								1	
윤	CAUSE (Disease or inju		DUE TO	(OR AS A	CONSEO	UENCE O	F):									
E	resulting in death) LAS	т 📗					•								İ	
빙						-									-	
4	PART ii. Other significa	nt conditions	contributing to	desth bu	t not re	eulting	In the ur	derlying	g cause	given in I	Part i. 24a.	WAS AN	AUTOPSY MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
MEDICAL	THEATTO	MIC	COPD	Ala	Crit	SIM	erz	a	1260	use,	_ 10	YES 2	- 4		COMPLETION DF CAUSE DF DEATN?	
¥	CVA, DV	1													1 _ YES 2 _ NO	
PHYSICIAN:	DID TOBACCO U	-	RIBUTE TO CA	USE OF	DEAT	TH YE	S 🔲 I	40 C	UNC	ERTAIN	ı iX					
S	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HQSPITAL:	2	6. PLACE	OF DEA	TH (Check									
YS	1 TYES 2 NO		1 Inputient 2	_	itlent 3	□ DOA			o 5 □ Re	sidence (6 Other (Spe	icffy)				
	27. MANNER OF DEATN 1 Natural 5	Pending	26a. DATE OF (Month, D			26b. TIM	E OF URY	28c. INJ WO	URY AT		26d. DEŞCRIB	E HOW IN	JURY OCC	CURED	12.1	
B	2 Accident	nvestigation					M		rES 2	NO					1780	
	3 Suicide 6 4 Homicide	— At hon (y)	ne, farm, :	street, tect	ory, office		1	261. LOCATION	l (Street a vn. State)	nd Number	or Rural R	oute Number,				
ᇦ	29e. CERTIFIER				_											
COMPLETED	(Check only		CIAN: To the best of													
Ö I		-		xamination	and/or In	rveatigatio	m, in my o	pinion, de	eath occur	red at the t	ime, data and	placa, and	d due to th	e cause(s)	and manner as stated.	
BE (BE SHATURE AND TITLE	OF CHRTIFIER	11/1/	nl	11	Λ			29c. LICE	ENSE NUM	BER		29d. DAT	E SIGNED	(Month, Day, Year)	
10	INTOOLE /	nu	UNYU	NA,	100	لىك			ASO	400	321ME	39812	▶J(114	28,1995	
-	AN IN OUT O	PERSON WHO	COMPLETEO CAUS	SE OF DEAT	TN (ITEM	27) (Type,	Print)	11-	101	4	AA.	7 ./	1 8 8	J	21/	
H	31. BATE FILEO (Month. Day 1	BAU (K)	33 FG10 PA	TO HONE	IUI I	1403	bute	110-	f BA	711.	BAC	1 . 1	v(T)	خداة	¥15	
	AUG 0 1 199	35 Ju	IN WINDS	TIME	425											

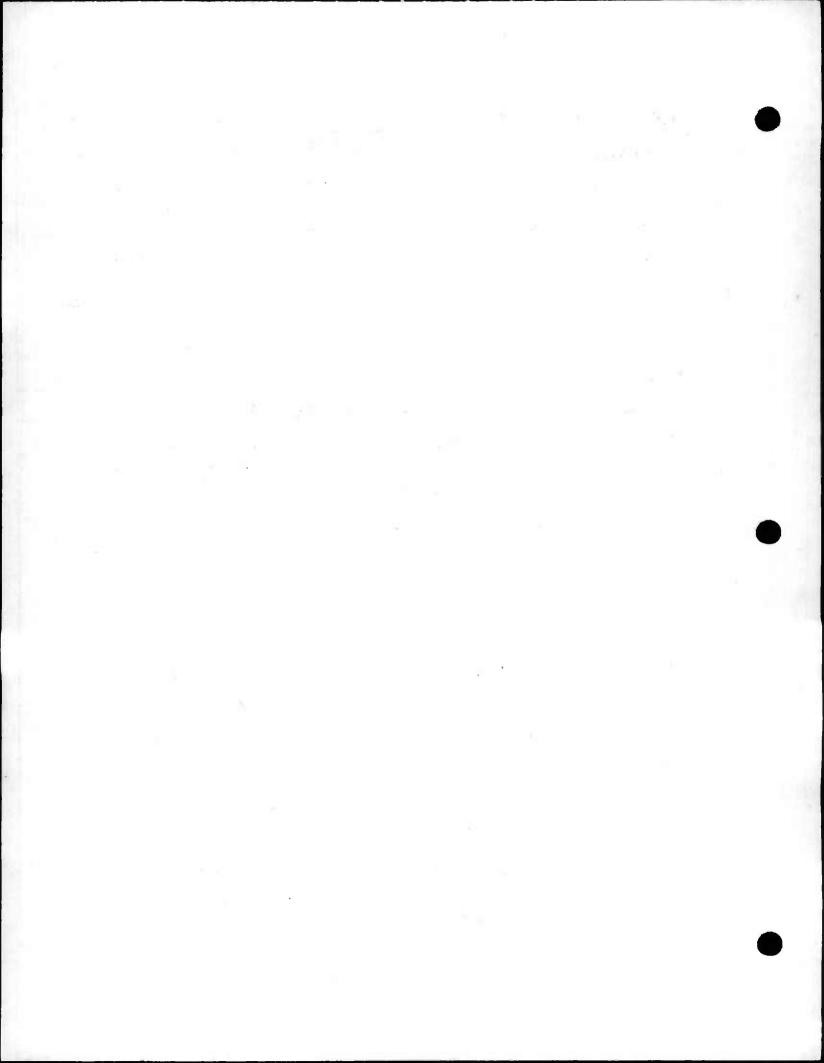
TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760



BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hours after death. Page 6 may be retained by the hospital or attending physicial	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trope filled within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYGIEN			
- 1	1. DECEDENT'S NAME (First, Middle, Last)			DARIMEA	IOV	2. DATE OF DEATH		3. TIME OF DEATN	
	BORIS 4. SOCIAL SECURITY NUMBER		In yrs. last birthday)	RAKHMIN		JULY 27,	1995	10:11pmm	
	unknown 9a. FACILITY NAME (If not institution, give:	1 🔀 M 2 🗌 F	44 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN. OR LOCATION OF D	7. DATE OF BIRTH	951 Coun	RUSSIA	
5	132 PITTSON C		TON _{T.E.}		NGS MIL		9c. COUNTY OF DEATH BALTIMORE		
Š	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	v	I to OIT	Y, TOWN OR LOCAT					
DIR	MARYLAND	BALTIMORE	100. 011		GS MILI	S		10d. INSIDE CITY LIMITS? 1 2 YES 2 NO	
IAL	100. STREET AND NUMBER PITT		10	, ZIP CODE		10g. CITIZEN OF WHAT COUN			
NEF	132 PITTSON CI				211		RUSSIA		
BY FUNERAL DIRECTOR	1 Marriad 2 Married 3 Widowed 4 XDivorced	12. WAS DECEDENT EVER IN FORCES? 1 TYES IF YES, GIVE WAR OR DA	2 NO	If yes, sp		NIC ORIGIN? (Specify Yee in, Puerto Rican, atc.) y:	14. RACE — American Indian, Black, White, etc. Specify: WHITE		
TED	15. DECEDENT'S EDU (Specify only highest grade	(Give kind of a	USUAL OCCUPATION	ON ist of working	16b. KIND OF BUS	BUSINESS/INDUSTRY			
PLE	Elementary/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT us	RVTSOR		MACH	OP		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	•		RVIDOR	18. MOTHER'S NA	ME (First, Middle, Maiden		01	
BE C	ABO	RAI	KHMINOV		ROSA		RAKHMIN	OVA	
5	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code MD A DO DA KLIM THOU							N W 12/25	
	MR. ABO RAKHMINOV 83-00 TALBOT ST, APT. 4-H KEW GARDENS, N.Y 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION - City of Town, Steple								
	tX Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	noval from Stata Cem				1995 BA	LTIMORE	, MD	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, N								
	23. PART I. Enter the diseases, pr	complications that caused	the deeth. Do r					Approximate	
	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) AS DOE TO OR AS A CONSEQUENCE OF:								
z	Depression								
5	if any, leading to immediate								
	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	CDUE TO (OR AS A CONSEQUENCE OF):							
CERTIFICATION	reaulting in deeth) LAST	d							
	PART II. Other algnificant condition	na contributing to death b	ut not resulting i	n the underlying	ceuse given in	Part i. 24a. WAS AN	AUTOPSY 241	. WERE AUTOPSY FINDINGS	
SICAL						PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MEDIC							X	OF DEATH? 1 YES 2 NO	
PHYSICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YE		UNCERTAI	и 🗆 📗			
SICI	EXAMINER?	HOSPITAL:		OTHER:	e 5 🗆 Saeidense	6 Other (Specify)			
Ή	27. MANNER OF DEATN	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJ		28d. DESCRIBE NOW IN	JURY OCCURED		
BY	1 Natural 5 Pending 2 Accident Investigation	July 27.19	995 10:1	1P.M 10	ES 2 NO	Hanged Sel			
딢	3 Suicide 8 Could not be detarmined	28a. PLACE OF INJURY building, atc. (Spec	ny)	treet, factory, office		281. LOCATION (Street of City or Town, State)	nd Number or Rurai	Route Number,	
ZE	29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	CIAN: To the best of my knowl	TOIL C	ed at the time, date	and place, and due	132 Pittst	on Ci		
COMPLETED		R: On the beels of exemination						e) and manner as stated.	
BE C	29b. SIGNATURE AND TITLE OF STIFFEE	R			29c, LICENSE NUI	/BER	29d. DATE SIGNED	(Month, Day, Year)	
10 E	30. NAME AND ADDRESS OF PERSON WN	Deputy Me	edical E	raminer	D01085		July 2	7.1995	
			viri (ITEM 27) (Type,					,	
	Stanley Z Folso 31. DATE FILED (MONT) Day 1987 AUG 01 1995	A REGISTRAN'S SIGN	Judger Ware Judger	Labe 2	1204				

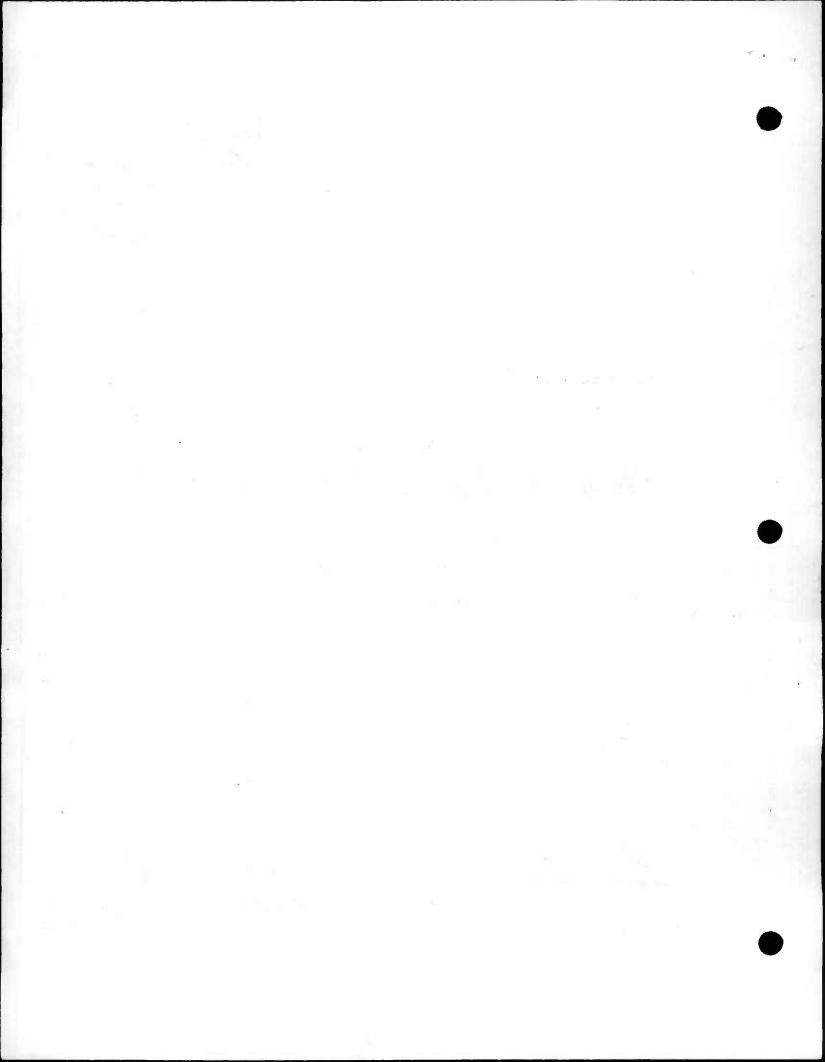
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,		_							2. DATE OF MONTH	DEATH	AY	YEAR	3. TIME OF DEATH
	GRACI		Ε.		NSON					JULY	2	25	1995	3:40 a M
	4. SOCIAL SECURITY NUMB		5. SEX	8. AGE (In yrs.		IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF (Month, D	BIRTH ay, Year)		8. BIRTHPLACE (State or Foreign Country)	
	232-32-5481 98. FACILITY NAME (# not in:		1 M 2 XF	92	YRS.		- 30			JUNE	24,1	_		ř VIRGINIA
DIRECTOR	WASHINGTON	ADVEN	4000 60	PITAL	<u>.</u>			PARK		EATH			NTY OF D	MERY
REC	10e. STATE	10b. COUNTY			10c. CIT	10c. CITY, TOWN OR LOCATION 10d.						10d. INSIDE CITY		
	WV	JEFFE	RSON			SHEP	HER	DSTOW	/N					LIMITS? 1 🖾 YES 2 🗌 NO
FUNERAL	10e. STREET AND NUMBER				101	2544				10g. CIT	US A	VHAT COUNTRY?		
BY FUN	11. MARITAL STATUS 1 Never Married 2 3 3 Widowed 4 Divor		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	ARMED (NO	1	yes, sp	ENDENT O	n, Mexica	IIC ORIGIN? (S n, Puerto Rice /:	Specify Yee n, etc.)	or No-	14. RACI	E — Americen Indien, t, White, etc.
9	15. DECE	DENT'S EDUC	ATION	16a. I	DECEDENT'S	USUAL OC	CUPATIO	ON		16b, Kil	ND OF BUS	SINESS/INE	USTRY	WHITE
	Elementary/Secondary (0-	highest grade (College (1-4 or 5 +	·) A	(Give kind of ville. Do NOT us	vork done d se retired.)	luring mo	st of workin	g					
COMPLETED	7				HOME	MAKEF	₹				НО	ME		
	17. FATHER'S NAME (First, Mil	III Comme	N HEDD							ME (First, Midd				
B	BENJAMIN F			ION 14 4 II INC	ADDOCOC	(0)				ESTELLA MUCK Oute Number, City or Town, State, Zip Code)				
5	HARRY L. R	OBINSO	N		19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6417 LYRIC LANE, FALLS CHURCH, VA 22044									
l	20e. METHOD OF DISPOSITION 1 № Burlet 2 □ Cremetton	cemetery, c	20b. PLACE AND DATE OF DISPOSITION (Name of cametery, cremetory or other piece)					DATE 26c. LOCATION — City or Town, State						
	4 Donation 5 Other (ENSEE	- ELMV	100D C			D ADDRES	S OF FAC	7/28	SHE	SPHER	DSTC	WN, WV
	· Char	les i	M. /	roce	m)	BR	.OWN	FUNE	RAL	HOME,				
	23. PART I. Enter the dis	seases, or co	omplications that	caused tha	laath. Do r									Approximata
	IMMEDIATE CAUSE (Fin		one cau	ad On Secti III	10.									Interval Batween Onset and Death
	disease or condition resulting in death)	PIRAT	PIRATORY INSUFICIEN						NCY			6 DAYS		
			DUE TO	OR AS A CONS	IS A CONSEQUENCE OF):									0 000
CERTIFICATION	Sequentially list conditions if any, leading to immediate		DUE TO	PIRATORY INSUFICIENCY 6 OR AS A CONSEQUENCE OF): 2 (RATION PNEUMONIA 2 OR AS A CONSEQUENCE OF): 2 (ONIC OBSTRUCTIVE PULMONARY 5 OR AS A CONSEQUENCE OF): 3 (SEASE							20445			
CAT	cause. Entar UNDERLY!! CAUSE (Disease or injur	IG	CH	CHRONIC OBSTRUCTIVE I					P	PULMONARY 5 VI DISEASE				5 VEARS
E	that initiated events reaulting in death) LAST	·	DUE TO	(OR AS A CONS	AS A CONSEQUENCE OF):									
H	reauting in death) LAST	d												
	PART II. Other algnificer	t conditions	contributing to	daath but not	raaulting i	n tha un	dariying	cause g	ivan in i	Part i. 24	. WAS AN		24b.	WERE AUTOPSY FINDINGS
MEDICAL	CONGE	ESTIVE	E HEA	ART F	AILU	RE				PERFORMED?				AVAILABLE PRIOR TO COMPLETION OF CAUSE
ME														OF DEATH? 1 YES 2 NO
	DID TOBACCO US		IBUTE TO CA	USE OF DE	ATH YE	S 🗆 N	10 🗆	UNC	ERTAIN	NE				
C	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:		ICE OF DEAT	H (Check o								
PHYSICIAN	t YES 2 YNO		1 Inpatient 2 I			4 🗆 Nurs	ing Home		sidence	6 Other (Sp				
	1 Natural 5 P	ending	(Month, Da		26b, TIMI INJ	URY		URY AT RK? 'ES 2 🗆	NO.	28d. DESCRI	BE HOW IP	NJURY OCC	CURED	
ĕ I	1 Sulaida	ould not be	28e. PLACE OF	F INJURY — At I	ome, farm, s	treet, lecto			NO	281. LOCATIO	N (Street a	nd Number	or Rural R	nute Number
Ë		etermined	building,	etc. (Specify)						City or To	wn, State)			
COMPLETED	29e. CERTIFIER (Check only	FYING PHYSIC	IAN: To the bast of	my knowledge, o	feath occurre	d at the tir	ne, date	end pleca,	end due	to the ceuse(s	and men	ner ee stat	ed.	
No.														end menner ee stated.
	29b. SIGNATURE AND TITLE	OF CERTIFIED						29c. LICE	NSE NUM	IBER		29d. DATE	SIGNED	(Month, Day, Year)
TO BE	1	N		HYSIC					23/			1 7	125	195
آ ۲	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH (IT	EM 27) (Туре,	Print)						-		
	1 6 44 - 0 -	10	A											
	MARIO 0	. BEL	LEDON.	NE, A	10	12/0	con	6KE.	55/0	NAL	W	205	R	DEKVILLE
	MARIO O 31. DATÉ FILED (Month, Day, N	BEL	JE DO N. 32. REGISTRAI	R'S SIGNATURE	10	12/0	con	6KE	55/0	NAL	W	205	R	DERVILLE D 2085Z



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to removal. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760

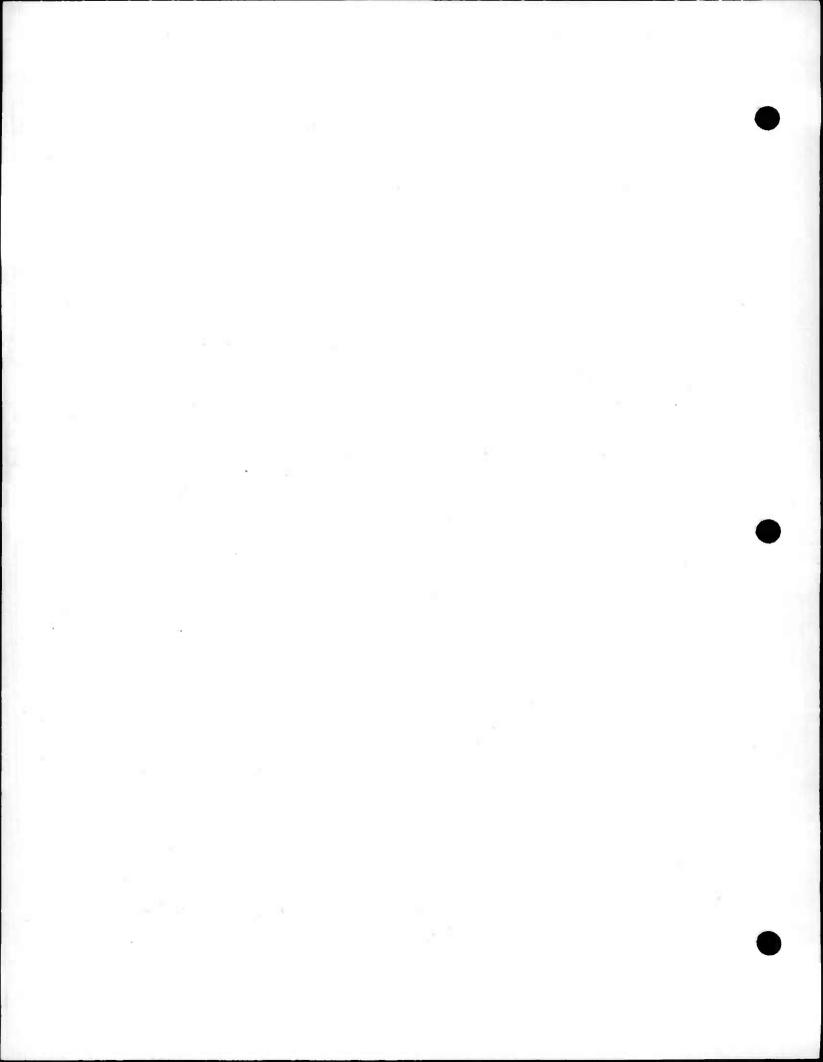
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at ence.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

1 - FOR STATE REGISTRAR		STATE OF M	ARYLAN	D / DEPAR CERTIF					MENTAL	HYGIEN REG. NO.	_		
1. DECEDENT'S NAME (First	, Middle, Leet)								2. DATE (OF DEATH	W.	YEAR	3. TIME OF DEATH
Dorothy 4. SOCIAL SECURITY NUM		5. SEX			_	nsor			Jul	y 2		995	0016
215-22-8459		1 M 2 X F	73	v. lest birthday) VRS.	IF UNDER	DAYS	HOURS	MINI,	7. DATE 0 (Month, 02/1			a. BIRTH Countr MARY	PLACE (State or Foreign
90. FACILITY NAME (If not in					9b. CITY	, TOWN O	R LOCATION	OF DE		0/ 22	9c. COU	NTY OF D	
4404 Old	Freder	ick Ave	e. Ap	ot D.	В	alti	more	9			BAL	TIMO	RE
100. STATE MARYLAND	10b. COUNTY	TIMORE		10c. CIT		OR LOCATI							10d. INSIDE CITY LIMITS?
10e. STREET AND NUMBER	DALI	TIMORE			BAL	TIMO	RE ZIP CODE				BOOM TO		1 X YES 2 NO
4404 01d Fr	ederick	Road					1229					S.A.	HAT COUNTRY?
11. MARITAL STATUS 1 X Never Married 2 3 Widowed 4 Divo	Merried	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	™ NO		Il yes, spe	ENDENT OF cify, Cuban, 2 NO	Mexican,	, Puerto Ri	(Specify Yes ican, etc.)		14. RACE	- American Indian, White, etc.
15. DEC (Specify only	EDENT'S EDUCA highest grade of	TION ompleted)	164	Give kind of w	USUAL O	CCUPATIO	N t of working		16b.	KIND OF BUS	SINESS/INC	USTRY	
Elementary/Secondary (0	l-12)	College (1-4 or 5+)			MEST					HOMEN	1AKER	2	
17. FATHER'S NAME (First, M VERMON ROBI	NSON						CORA	HAR	MON	iddle, Meiden			
LORRAINE BO				196. MAILING 5007	FRED	ERIC	d Number of	Rural Ro	ALTIN	MORE,	1, State, Zip 1ARYL	(Code)	21229
20a. METHOD OF DISPOSIT 1 Burlal 2 Crematic 4 Donation 5 Other		al from State	20b. PLA	CEAND DATE O	FDISPOS	ITION (Nan	ne of	28/9	OATE	20c. LO	CATION -	City or Tox	vn, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME													
1300 EUTAW PLACE BALTIMORE, MD 21217													
enock, or n	23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enter the disease or condition. Approximate interval Between Onset and Dasth												
Sequentially list conditi if any, leeding to imme- cause. Entar UNDERLYI CAUSE (Dissess or Inju- thet initiated eventa resulting in death) LAS	diate NG ry c.			NSEQUENCE OF									
PART II. Other significe							ceuse giv	en in P	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
GHUIVONI	repla	1 Hear	6	X pas	y ve				-	1 - YES	NO		COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
DID TOBACCO U		BUTE TO CAL				40 D	UNCE	RTAIN					
25. WAS CASE REFERRED TO EXAMINER? 1 X YES 2 □ NO	F	IOSPITAL:		LACE OF DEAT	OTHER		V						
27. MANNER OF OEATH	11	28e. OATE OF II	NJURY	28b. TIME	OF	28c. INJU	5X Resid	-		(Specify)	JURY OCC	CUREO (
coldent	Pending nvestigation	(Month, Da		UNJ	M	1 YE		NO S	Subje	et la	paco.	d to	Leat
	Could not be letermined	28s. PLACE OF building, a	Ic. (Specify)	HOW.	reet, fact	ory, office			281. COCAT City or	TION (Street at Town, Stete)	OF	or Aural Ac	LRK AVE
		N: To the best of m											end manner as stated,
250 SIGNATURE AND TITLE	OF CERTIFIER	Took	01	11			29c. LICENS				29d. DATE	SIGNED	Month, Day, Year)
DO, NAME AND AGORESS OF	PERSON WHO	COMPLETED CAUSE	OF DEATH	(ITEM 27) (Type,	Print)		Ο,	C.M	.E.			July	24 1995
31. DATE FILEO (Month, Day,	bar)	32. REGISTRAR		111 Pe	enn	Str	eet,	Ва	ltir	nore,	Ma	cyla	nd 21201
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TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	A	TO BE COMDIFIED BY BUXBLAN. MEDICAL CERTIFICATION
must be notified at once.	medical examiner	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	led in by the funeral dire i, or removal.	10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fibed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.
6 may be retained by the hospital or attending physician.	hours after death. Page	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within services after death. Page 6 may be retained by the hospital or attending physician.

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

HEGISTHAH				PERITI	CALE	OF DEATH		REG. NO.			
1. DECEOENT'S NAME (First,	ES .	REI	SEN	De	R		MO	TE OF DEATH DA		YEAR	3. TIME OF DEATH 5:45am M
4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1 Y		RS. 7. DA	E OF BIRTH		8. BIRTHI	PLACE (State or Foreign
060-50-8729)	1 🗌 M 2 💢 F	83	YRS.	MONTHS D	AYS HOURS MI		enth, Day, Year) EC. 14,	1911	Country NF.V	YORK
9a. FACILITY NAME (# not in:	stitution, give s	treet and number)			9b. CITY, TO	WN OR LOCATION O			9c. COUN	TY OF DE	EATH
HEBREW HOME		REATER W	ASHINGI	NO.	ROCK	VILLE			M	YIVON	SOMERY
RESIDENCE OF DEC	10b, COUNTY	1		18c CITY	TOWN OR L	OCATION					404 INDIOE OUTV
MARYLAND		GOMERY		100, 0111,		VILLE					10d, INSIDE CITY LIMITS? 1 XYES 2 NO
10e. STREET AND NUMBER						10f. ZIP CODE			10g. CITIZ	EN OF W	HAT COUNTRY?
6121 MONTRO	SE RO	AD 12. WAS GECEDEN	T 5350 MI 11 0			20852					
1 Never Married 2 3 Widowed 4 Divo		FORCES? 1	YES 2	Mo.	If yo	DECENDENT OF HIS DECENDENT ican, Puarl	GIN? (Specify Yea to Rican, etc.)	or No-	Black	— American Indian, , Whita, alc. y: WHITE	
	EDENT'S EDU	CATION	160	DECEDENT'S U	ISHAL OCCU	DATION		6b. KINO OF BUS	INTERCUNION		
	highest grade			(Give kind of wo life. Do NOT use	ork done durii	ng most of working	- 1	oo. KINO OF BUS	INESS/INUL	751 RT	
, , , , , , , , , , , , , , , , , , ,	-,	2		DENTA	AL HYC	GIENIST		DENT	'ISTR'	Z	
17. FATHER'S NAME (First, Mi	ddle, Last)					18, MOTHER'S	S NAME (Firs	t, Middle, Maiden			
BARNET COHEN IDA WEBER											
19a. INFORMANT'S NAME (Type/Print) MRS. NOREEN HALPERN 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4517 CHERRY VALLEY DRIVE ROCKVILLE, MD 20853											
20a. METHOD OF DISPOSITION 1 Surfal 2 Cremation 3 Removat from State 4 Donation 5 Other (S) 20b. PLACE AND DATE OF DISPOSITION (Name of June 1) 20b. PLACE AND DATE OF DISPOSITION (Name of June 1) 20c. LOCATION — City or Town, State 3 DDEAN MEMORIAL GARDENS 7-31-1995 OLNEY, MD											
21. SIGNATURE OF FUNEL & SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC.											
6010 REISTERSTOWN ROAD BALTIMORE, MD 21215											
23. PART I. Enter the di	seases of g	omplications tha	t causad tha	death. Do no	t enter the	moda of dying,	auch aa ce	ardiac or respi	retory arra	st,	Approximata
IMMEDIATE CAUSE (Fin	ider lattura.	List only ona cau	isa on each li	na.							Interval Batwean Onsat and Death
disease or condition	→		4L2H	EIM	ER C	214	1574S	F			6un
Todaking in Court,		DUE TO	(OR AS A CONS	SEOUENCE OF)	:						1 0 1 / -
Sequantially list condition	ons.	b									
If any, leading to immed cause. Entar UNDERLY	liate	DUE TO	(OR AS A CONS	SEOUENCE OF):	:						
CAUSE (Disease or injur		C. DUE TO	(OR AS A CONS	SECULENCE OF							
that initiated evants resulting in death) LAST	r ((on no n como	LOGENOE OF).	•						
		d									
PART II. Other algorificat	nt condition	s contributing to	death but no	t resulting in	the unda	rlying cause giver	in Part i.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
2012	MICE	D/70	KNEK					1 TES 2			COMPLETION OF CAUSE OF DEATH?
						·			(1 YES 2 NO
DID TOBACCO US		RIBUTE TO CA					AIN 🗆				
25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO	MEUICAL	HOSPITAL:			OTHER:						
27. MANNER OF DEATH		1 Inpatient 2 28a. DATE OF		28b. TIME		Home 5 Rasider		her (Specify)	IIIBY OCC	IDEO	
	Pending	(Month, D		INJU	RY	WORK?		COUNTRY NOW II	SONT OCC	UNED	
2 Sulaida	nvestigation	26a. PLACE O	F INJURY — At	home, farm, str			_	CATION (Street a	nd Number o	or Rural Ro	oute Number
	Could not be letermined	building,	etc. (Specity)					ty or Town, State)			
29a. CERTIFIER	FYING PHYSIC	CIAN: To the beat of	my knowledge.	death occurred	at the time	data and place, and	due to the	rausala) and man	nar an elete	4	
											and manner as steted.
29b. SIGNATURE AND THE						29c LICENSE	NUMBER		204 DATE	SIGNED	(Month One March
(a)	20	hone	20			D3	322	4	> 7/1	14	29,1900
30. NAME AND ADDRESS OF	PERSON WHO			ГЕМ 27) (Туре, F	Print)			44 :	, 40	- (-111173
BAM TR	CHAM	U 02 U	DEOL1	nons	ton	Dr. Ru	chu	elle 1	101	204	29,1995
ALIG (Month Day)	95	82. EGISTA	R'S STATT IE	K							

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE PUREAL DISTECTOR: After this becensioned by the attending physician and completely filled by the fumeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 follower stars death with the State Dark of Health and Mental Horsien prior in hursing returned in presence of the stars and the star with the State Dark of Health and Mental Horsien prior in hursing returned.	IMPORTANT II Iam 28 smarket or law 23 shows any injury, or other fraumatic event the markets are more to another a constitution of the constitutio
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31. DATE FILEO (Mo

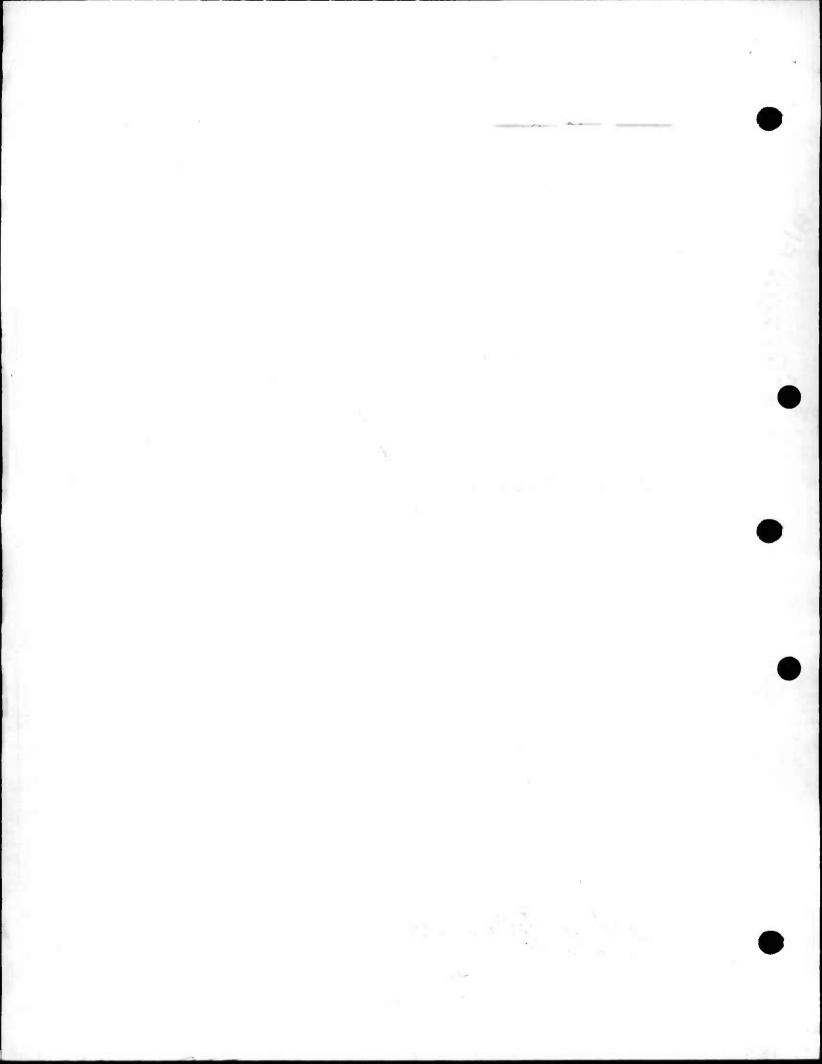
0 1 1995

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02. REGISTRAR'S SIGNATURE

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH CAROL MARGARET RIES 0857 1 4. SOCIAL SECURITY NUMBER Inh 6. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Gay, Year) JULY 9, 1935 IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreig HOURS 1 M 2XX I 212-40-5556 60 YRS. BALTIMORE, MARYLAND 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH NORTHWEST HOSPITAL CENTER RANDALLSTOWN DIRECTOR BALTIMORE RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE CITY BALTIMORE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 21209 WHAT COUNTRY? 10g. CITIZEN OF 1803 THORNBURY ROAD USA 11, MARITAL STATUS
1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Maxicen, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. BY Specify: WHITE 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp SPECIAL EDUCATION SPECIAL EDUCATION N/A N/A 17. FATHER'S NAME (First, Middle, Last) t6. MOTHER'S NAME (First, Middle, Maiden Surname) PHILANDER L. RIES RUTH A. BURGEMEISTER BE 190. INFORMANT'S NAME (Type/Print) MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LAGAN COURT BALTIMORE, MARYLAND 21236 2 20s. METHOD OF DISPOSITION
1 N Burial 2 Cremation 3 Removal from State
4 Donation 5 Differ (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE PARKWOOD "CEMETERY" JULY 29, 1995 BALTIMORE, MARYLAND 22. NAME AND ADDRESS OF FACILITY LASSAHN FUNERAL HOME, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE INC Mho 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such ee cerdiac or respiratory arrest, shock, or heart failure. Liet only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): PSUS CERTIFICATION Sequentially list conditions, OUT TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events regulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 TYES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 5 Pending M BY 1 YES 2 NO Investigation 28s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide detarmined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 (MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day. BE 29c LICENSE NUMBER 9 30. NAME/AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Naryhh



Pages 1, 2, 3 should permit. funeral director, page 5 should be detached for use as the burial-transit been signed by the attending physician and completely filled in by the pt. of Health and Mental Hygiene prior to burial, cremation, or removal. 6

certificate has be

this c

DIRECTOR: After the hours after death

HOSPITAL FUNERAL E

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31. DATE FILED (Month, Dey, Year)
AUG 0 1 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

ROCENZ)

his Driveles Re

ITEM: 17. PER F.H. FILM G-726 8/1/95 t.t FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF OEATH JU lliam 995 0 3:45 P George 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign -20-836 69 (Month, Day, 1XM 2 - F 01 Maryland 9a. FACILITY NAME (If not institution, give street and number) CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Maryland DIRECTOR Univ. of Maryland Medical Center timore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Manchester Md. Carroll 1 X YES 2 - NO 10s, STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2911 Tulip Way 21102 U.S.A. 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 X YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES B 3 Widowed 4 Divorced WW II White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done itle. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Manager National Cash Register 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) CHARLES J. SETTAN, SR. Ħ William Settan Lula Turner BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary F. Settan 2911 Tulip Way, Manchester, Md. 21102 og Q METHOD OF DISPOSITION 20a, METHOD OF DISPOSITION

1 X Burlel 2 Cremation 3 Removal from State

4 Departure 8 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must Maryland Veterans Cem. July 31,1995 Owings Mills, Md. Donation 8 - Other (Specify) _ examiner 21. SIGNATURE OF FINEHAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Eckhardt Funeral Chapel 21117 11605 Reisterstown Rd., Owings Mills, Md. medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feliure. List pnly one cause on each line. Approximate Interval Between **IMMEDIATE CAUSE (Fine)** Onset end Death event, the disease or condition r 1 ac lamponade
DUE TO (OR AS A CONSEQUENCE OF): Vardiac 20 minutes resulting in death) coronary other traumatic CERTIFICATION 5 years Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART ii. Other aignificent conditione contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE amy 1 YES 2 NO shows ; OF DEATH YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28s. DATE OF INJURY 28d. OESCRIBE HOW INJURY OCCURED marked, 28b. TIME OF INJURY (Month, Day, Year) 1 Natural
2 Accident 5 Pending 1 YES 2 NO ВУ 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, tectory, office building, atc. (Specify) 28 Is 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 29b. SIONATURE-AND-TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year)

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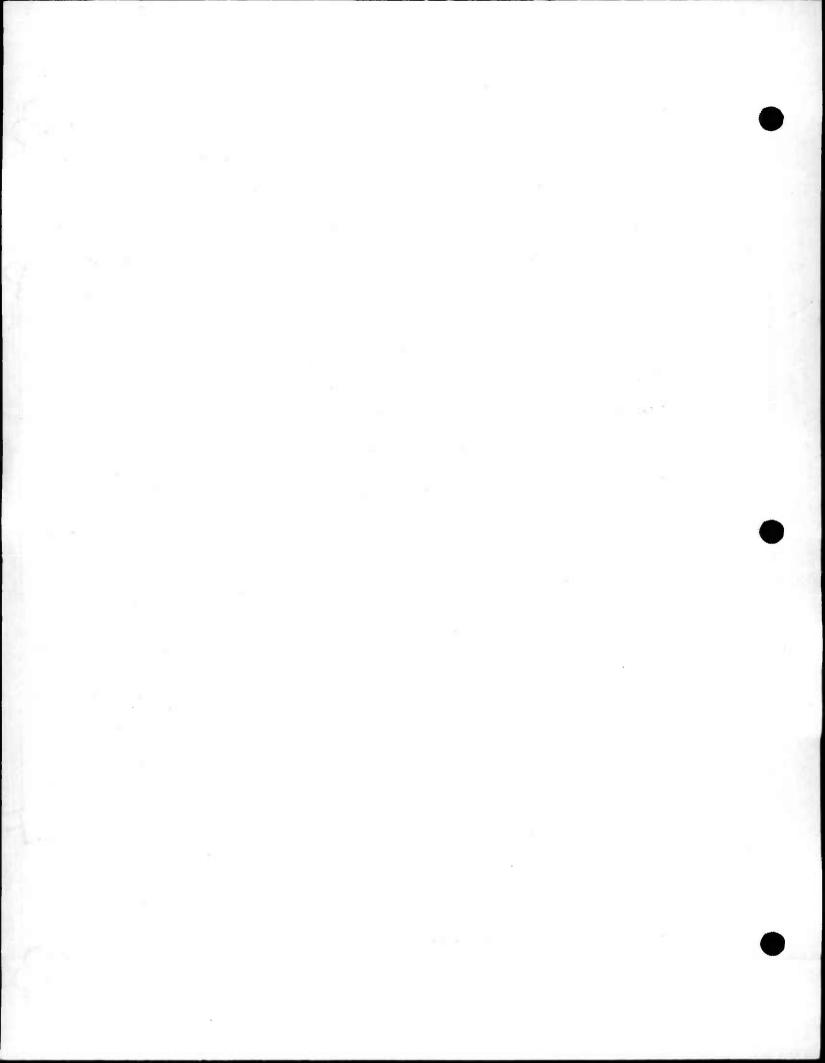
S. GREENE

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the jurial-transit nermit. Pages 1.2 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSIC	TO THE FUNERAL DIRECTOR: After this ce	be filed within 72 hours after death with the	IMPORTANT: If Item 28 is marked,	

	FOR STATE REGISTRAR	STATE OF MARY		TMENT OF H		MEN	TAL HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)					2. D	ATE OF DEATH			3. TIME OF DEATH
	BETTY	100	904	WEAMACH		M	M HTMO		YEAR	3:05 am M
	4. SOCIAL SECURITY NUMBER 5	5. SEX 6. AC	GE (In yrs. last birthday)	IF UNDER I YEAR	IF UNDER 24 HRS		ATE OF BIRTH		8. BIRTH	IPLACE (State or Foreign
	216-24-5724	1 🗌 M 2 🔀 F	65 YRS.	MONTHS DAYS	HOURS MIN.		Month, Day, Year)	1929 Md.		Md.
	9a. FACILITY NAME (If not institution, give street	et and number)		9b. CITY, TOWN	R LOCATION OF		19. 3., .	9c. COUN	ITY OF D	
R	Saint Joseph Medic	al Center		Tow	son, Mar	vland	d	R	altim	ore
ᇈ	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY					,				
DIRECTOR	The reach	ltimore	10c. CIT	Y, TOWN OR LOCAT						10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	TCIMOLE		Tow	ZIP CODE					1 YES 2 X NO
P. P.	1229 Providence Rd	ı		101	21286			10g. CITIZ		VHAT COUNTRY?
¥		2. WAS DECEDENT EVE	D IN I I C ADMED				rincur zacini			S.A.
BY FUNERAL	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	ES 2 XNO	If yes, sp	ecity Cuban, Mexi 2 2KNO Spe	can, Pue	RIGIN? (Specify Yes irto Rican, etc.)	or No-	Black	— American Indian, k, Whita, atc. White
	15. DECEDENT'S EDUCAT	TION	10. DECEDENTIE	USUAL OCCUPATION						WILLCE
	(Specify only highest grade cor	mpleted)		vork done during mo		i	16b. KIND OF BUS	INESS/INO	USTRY	
PL	11	College (1-4 or 5+)	111 100 100	Maker			Own H	Tome		
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S	IAME /Fi	rst, Middle, Maiden			
	Shelley		Lee		Myrt1		ou, mode, maden	our name)	Bo1	.ger
10 INFORMANT'S NAME (TOURS)									.90-	
2	Martin A. Schwemme	r		as 10e						
	20a. METHOD OF DISPOSITION 1XPBurlet 2 Cremetion 3 Remove		20b. PLACE AND DATE O		me of		DATE 20c. LO	CATION C	City or To	wn, Stata
	4 Donation 5 Other (Specify) Dulaney Valley Mem. Gdns. 8/2/95 Timonium. Md.									Md.
	21. SIGNATURE OF SUMERAL SERVICE LIGHTS AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc.									
	A soubt	KMCC.	-	1050	Towsor	ı Fu	neral Ho Towson,	ome,	Inc.	14
	22 PART I. Enter the diseases, or con	nplicetions that csur	sed the daeth. Do n	ot antar tha mo	de of dying, su	ich as d	cardiec or respi	ratory arre	est.	Approximata
	shock, or haert failure. Lis IMMEDIATE CAUSE (Finel	t only one cause or	each line.					,	,	intervsi Between Onset and Death
	disease or condition	MULTIPLE	CEREBRAL B	EMBOLL						9 DAYS
	resolding in death) , a.		S A CONSEQUENCE OF							
N	Sequentially ilst conditions, b.									
CERTIFICATION	if sny, leading to immediate cause. Enter UNDERLYING	DUE TO (OR A	S A CONSEQUENCE OF	7):						
5	CAUSE (Disease or Injury C	OHE TO (OR A	S A CONSEQUENCE OF							
Ē	thet initiated events resulting in deeth) LAST	30E 13 (OR A	S A CONSEQUENCE OF) ;						
8	d									_
	PART ii. Other significent conditions of	ontributing to death	but not resulting in	n the underlying	cause given i	n Pert i	. 24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
음	TRICUSPID VALVE B	EPLACEMEN	VTTV				1 TYES 2	1		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL										1 TES 2 NO
ÿ	DID TOBACCO USE CONTRIB	SUTE TO CAUSE	OF DEATH YE	S 🗆 NO 🗆	UNCERTA	IN 🗆				
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	28. PLACE OF DEAT	H (Check only one) OTHER:						
ı. YS		Inpatient 2 - ER/O		4 - Nursing Hom		8 🗆 0	Other (Specify)			
	27. MANNER OF OEATH 1 Neturel 5 Pending	28s. OATE OF INJUR (Month, Day, Yes)	r) 28b. TIME	JRY WO	RK?	28d.	DESCRIBE HOW IN	JURY OCC	URED	
à	2 Accident Investigation	280 DI ACE OF IN III			ES 2 NO	!				
	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (S	RY — At home, farm, a pecify)	treet, factory, office		28t. L	OCATION (Street as City or Town, State)	nd Number o	or Runal R	oute Number,
COMPLETED	29a. CERTIFIER									
MP	(Check only									
8	one) 2 MEDICAL EXAMINER: (on the bears of examine	mon and/or investigation	n, in my opinion, d	eath occured at 1h	e time, c	data and place, and	dua to the	cause(s)	and menner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	1 2 1			29c. LICENSE N	JMBER		29d. DATE	SIONED	(Month, Day, Year)
<u>و</u>	38. NAME AND ADDRESS OF PERSON WHO C	SIN TO THE POPULATION OF THE P	DEATH HERE		H 4397	4		Ju	17	10,16
	ALILCE HSIEH 7620 Y				ID 21204				•	
	31. OATE FILED (Month, Day, Year)	32. REGISTRAR'S SI			21204				···	
	AUG 0 1 1995 July	Student	white							
	1000								_	



DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital TO THE FUNERAL DIRECTOR. After this centrificate has been signed by the attending physician and completely filled in by the timeral director, page 5 should be detached in the filled that with the State Date of Health and Mental Written night of the Indian Compution or company.	BALTIMORE, MARYLAND	hours after death. Page 6 may be retained by the hospital	led in by the funeral director, page 5 should be detached f	Or removal
THE THE	DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fill	he filed within 72 hours after death with the State Dent of Health and Mental Hydiene prior to burial cremation

		1 - STATE REGISTRAR	STATE OF MA				OF HEALT		MENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last)					01 01		2. DATE OF DEATH MONTH DA		3. TIME OF DEATN	
		BERNADINE	1		SEYMOUR				July 28	, 1995	5:00 a M	
		4. SOCIAL SECURITY NUMBER -219-20-7925 -220-12-9052	5. SEX 1 M 2 F	6. AGE (In yrs. last	t birthday) YRS.	IF UNDER 1	YEAR IF UN	DER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)		BIRTNPLACE (State or Foreign Country)	
3 should		9e. FACILITY NAME (If not institution, give a	A 70				TOWN OR LOC	ATION OF DE	7-28-25	Ma 9c. COUNTY	ryland of DEATH	
2,38	OR	29 Haddington Rd. Lutherville Baltimore										
₩	DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT			10c. CIT	Y, TOWN OR				10d. INSIDE CITY		
permit. Pages	PIO	Maryland Bal	timore		Lutherville					LIMITS?		
	RAL	10e. STREET AND NUMBER	10.							10g, CITIZEN	OF WHAT COUNTRY?	
020 physician. burial-transit	FUNERA	29 Haddington	Rd.	EVER IN U.S. AR	uen	19 W	2109		UA ARIANIA (Passille, Van	U.S.		
21215-0020 al or attending physician. for use as the burial-tra	BY	1 Never Merried 2 Married 3 Wildowed 4 Divorced		YES 2 N		36	yes, specify C	eben, Mexice	IIC ORIGIN? (Specify Yea n, Puerto Rican, atc.)		RACE — American Indian, Black, White, atc. Soscity: White	
=	ETED	15. DECEDENT'S EDU (Specify only highest grade		(Gr	ive kind of a	USUAL OCC	CUPATION iring most of wo	orking	16b. KIND OF BUS	SINESS/INOUST	RY	
D 2 Spital o		Elementary/Secondary (0-12) 12 yrs	College (1-4 or 5+)		nage	ment			Hill's	Timor		
the hospital detached fo		17. FATHER'S NAME (First, Middle, Last)			riuge	Ilauic	18. M	OTHER'S NA	ME (First, Middle, Meiden			
RYL ed by 1	i w		choltholt						herine	Diete		
BALTIMORE, MARYLAND er death. Page 6 may be retained by the hospit the funeral director, page 5 should be detached the transitiner must be notified at once		19a. INFORMANT'S NAME (Type/Print) John R.W. Seymo	1774						Route Number, City or Town			
ALTIMORE, I death. Page 6 may be funeral director, page		20e. METNOD OF DISPOSITION		20b. PLACE A	ND DATE (OF DISPOSIT		<u>а. Lu</u>	therville,	CATION - City		
ALTIMORE, leath. Page 6 may be funeral director, page		1 🔀 Burlel 2 □ Cremetion 3 □ Rem 4 □ Donation 5 □ Other (Specify)		Loud	on P	ark			7-31 Bal		. Maryland	
ath. Pa		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	//			AME AND ADD		CILITY			
BALTIN hours after death. Pag d in by the funeral dis or removal.		Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate										
within 24 I within 24 I pletely fille cremation,		iMMEDIATE CAUSE (Final disease or condition resulting in death)	s. ACUTE DUE TO (0	CAR OR AS A CONSEO	D(b	PUN	10114	Ry 1	NSUFFIC	IENC	Interval Between Onset and Death	
S, P.O. BOX 6876 death certificate be executed a attending physician and com ental Hygiene prior to burial, inv. or other traumatic ev	ERTIFICATION	Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events b. CORONARY THROMBOSIS - PROBLE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
eath ce attendin rital Hyg	Ë	resulting in deeth) LAST	d									
0 6 5 3	ICAL C	PART II. Other significent condition			suiting	in the und	erlying caus	e given in			24b. WERE AUTOPSY FINDINGS	
Sign Sign	MEDICA	/ /	RTENSI						PERFOR	/	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF OEATH? 1 YES 2 NO	
S b s b		DID TOBACCO USE CONTI	RIBUTE TO CAU					CERTAIN	1 🗆			
VITA NN: The ficate h State [SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	er mayor	1100	OTHER:		/	· · · ·			
CIA PETITION		27. MANNER OF DEATH	26s. DATE OF IN	NJURY	26b. TIM	E OF 2	8c. INJURY AT	Residence	6 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCURE	:D	
DING PHYS After this of death with	ВУГ	1 Natural 5 Pending 2 Accident Investigation					WORK?	□ NO				
TTENDI TTENDI TTOR: A after d	ETED	3 Suicide 6 Could not be datarmined	28e. PLACE OF building, at	INJURY — At honic. (Specify)	ne, farm, s	rtreet, lector	y, office		261. LOCATION (Street e City or Town, Stete)	nd Number or Au	ural Route Number,	
보 보 전 =	귤	29a. CERTIFIER (Check only one)										
THE HOSPITAL THE FUNERAL filed within 72 i	8	2 MEDICAL EXAMINE		mination and/or in	westigatio	n, in my opi				d due to the ceu	use(s) and manner es stated.	
TO THE HOSPIT TO THE FUNERA be filed within 7	B	296. SIGNATURE AND TUTLE OF CERTIFIES						ICENSE NUM		29d. DATE SIG	GNED (Month, Day, Year)	
263	유	30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUSE	OF OEATH (ITEM	27) (Type,	Print)	10,	143/8)	-1/2	-8/75	
1		Robert W. Lisle	20 E. Ti	monium	Rd.	Timon	ium, M	id. 21	.093			
V		AUG 0 1 1995	R, REGISTRARY	BIGNATURE								

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DIRECTOR

FUNERAL

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MEDICAL

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BE

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NAME AND ADDRESS OF PERSON

1 1995

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

W. REGISTRAR'S SIGNATURE

111

1 -

ITEMS: 23 PART I, 27, 28a-f, PER NEO FILM G-726 8/7/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH CHRISTIAN HOPKINS SMITH III.Y 1995 8:14 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) APRIL 28,1959 IF UNDER 1 YEAR IF UNDER 24 HRS 6. BIRTHPLACE (State or Foreign 218-90-5205 36 1 M 2 - F DAYS HOURS YRS. GERMANY 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 754 213th. STREET PASADENA ANNE ARUNDEL RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND ANNE ARUNDEL GLEN BURNIE 1 YES 2 X NO STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 21061 145 OLEN DRIVE U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ★★★NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married if yes, specify Cuban, Mexican, Puarto Rican, etc.)
1 ☐ YES 2 ♠ NO Specify: Specify: 3 Widowed 4 Divorced Specify: WHITE 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high N/A N/A Elementary/Secondary (0-12) 12 LABOR ER CONSTRUCTION TRADE 17. FATHER'S NAME (First, Middle, Last)
DONALD HOPKINS SMITH 16. MOTHER'S NAME (First, Middle, Maiden Surnan ADKINS MARY ALDENA 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 145 OLEN DRIVE, GLEN BURNIE, MARYLAND SANDRA LEE SMITH 21061 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 7/31 20c. LOCATION - Cify or Town, Stata 1 N Buriel 2 Crem on 3 - Removal from State GLEN HAVEN MEMORIAL PARK 4 Donation 5 Other (Specify) GLEN BURNIE, MARYLAND 1995 21. SIGNATURE OF FUNERAL SERVICE LICENSEE SINGLETON FUNERAL HOME, 22. NAME AND ADDRESS OF FACILITY 1 SECOND AVENUE, del 104 GLEN BURNIE, MARYLAND 21061 23. PART I. Enter the diseases, or complications that call and the deeth. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one cause Interval Batwaan IMMEDIATE CAUSE (Final Onset and Death disease or condition NARCOTIC AND ALCOHOL INTOXICATION resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? YES 2 NO OF DEATH? 1 ☐ YES 2 ☐ NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: TY YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Rasidenca 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural FOUND 7-27-95 **UNKNOWN** 1 YES 2 NO UNKNOWN 2 Accident 26a. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number City or Town, State) 754 213 11 51 8 XX Could not be 4 Homicide datarmined FOUND AT HOME PASADENA, MD. 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

O.C.M.E.

Penn Street, Baltimore, Maryland 21201

Pages 1, 2, 3 permit. the funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. 늄 notified hours after death. Page 6 may be ě must examiner the medical n and completely filled in by to burial, cremation, or remo cremation, or event, patnoaxa traumatic the death certificate be the attending physician Mental Hygiene prior to Hygiene prior 6 signed by the Health and I been sign. t. of Hear has by Dept. 23 OR ATTENDING PHYSICIAN: The certificate h 0 offer this ce eath with the marked, After 80 DIRECTOR: / 28 TO THE HOSPITAL

TO THE FUNERAL I

DE filed within 72 h

IMPORTANT: If II HOSPITAL

BOX 68760

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DIVISION OF VITAL RECORDS, P.

BALTIMORE, MARYLAND 21215-0020

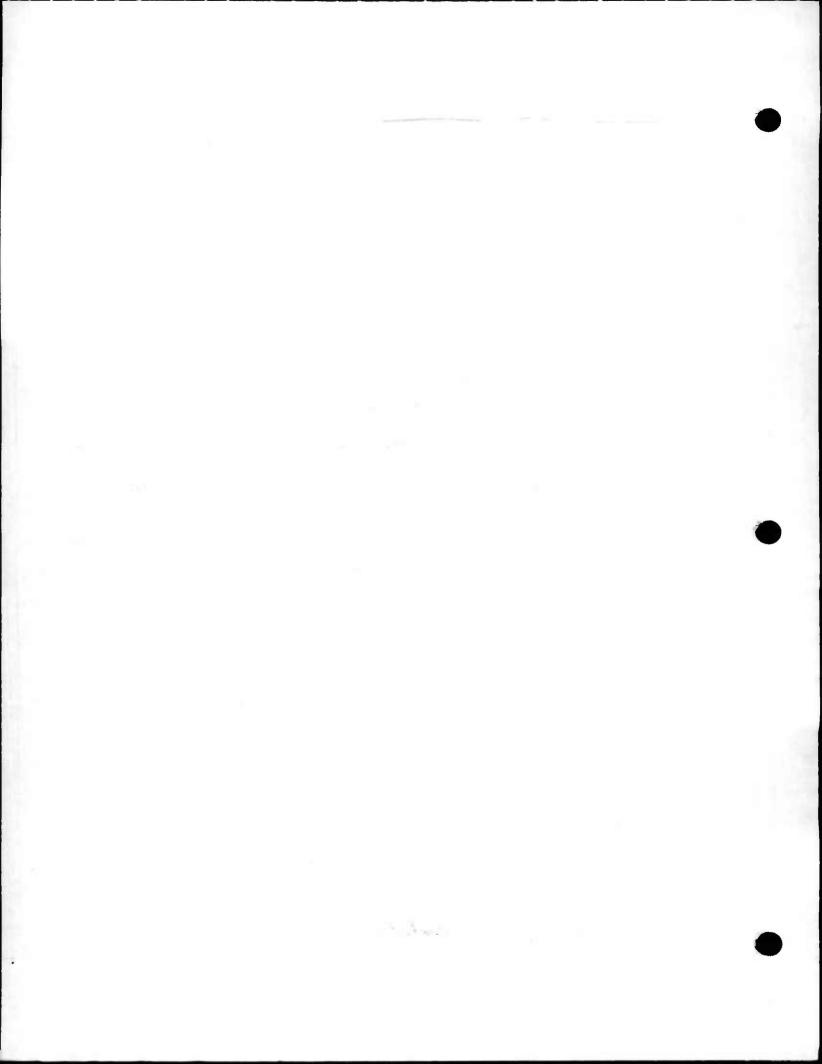
DHMH-16 Ray 1/89

JULY 28,1995

20 EE | 10 F | 10 72 F | 67 WH

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perm	be field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT If item 28 is marked, or item 23 shows any injury, or other traumatic event the medical examiner must be notified as another.
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	FilmG, 726, item	#1, 8/1/95,0	cyw, per	f.h.			90	23111		
	FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	GRACE ELLZ	ABETH S		DEATH	2. DATE OF DEATH		3. TIME OF DEATH		
	GRACE -	E. SA	TITH	-			7 19	15 10:30 A m		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF WIRTH		. BIRTHPLACE (State or Foreign		
	220-68-6049		30 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 08-27-191		W YORK		
l "	90. FACILITY NAME (If not institution, give st	EATH		Y OF DEATH						
5 NORTH ARUNDEL HOSPITAL GLEN BURNIE, MARYUN AUNE ARUN										
DIRECTOR										
RAL	109. STREET AND NUMBER 7879 CRILLY ROAD 109. CITIZEN OF WHAT COUNTRY? 21061 U.S.A. 11. MARITAL STATUS 11. MARITAL STATUS 11. Never Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American Indier 19 yes, specify Cuban, Mexican, Puerto Rican, atc.) 19 yes, specify Cuban, Mexican, Puerto Rican, atc.)									
빌										
	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES XX NO Specify: WHITE									
	15. OECEDENT'S EDUC (Specify only highest grade	CATION completed)		Work done during mos		16b. KIND OF BU	SINESS/INDUS	STRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+) N/A	SUPERV			MARYLAN	ND MAN	OR		
00	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden				
BE	HENRY 190. INFORMANT'S NAME (Type/Print)	PECK			BESSIE		•			
유	WILLIAM HENRY BEN	NOIT	210 I	DAFFODIL	ROAD, GI	Route Number, City or Tow EN BURNIE	, MD.	^{ode)} 2 1 060		
	20b. PLACE AND DATE OF DISPOSITION OATE 20c. LOCATION — City or Town, State									
	4 Donation 8 Dotter (Specify) GLEN MEMORIAL PARK 1663 GLEN BURNIE, MARYLAND									
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	111	1 SECO	ND AVENU	GLIT'S INGLET	ON FUNI	ERAL HOME,		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MARYLAND 21061									
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feliure. List only one cause on second interval Returned.									
	IMMEDIATE CAUSE (Finel							intarvsi Between Onset and Death		
	resulting in death)	OUE TO (OR AS	CONSEQUENCE	E SEPS	12			ONE WEEK		
z		GRANINI	CYTOP	ENIA				NEWER		
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSCOURAGE OF): St. AACH									
15	CAUSE (Disease or injury	DUE TO COR AS	CONSEQUENCE O					DIX MONTHU		
E	thet initieted events resulting in death) LAST	4	TOTAL OF THE PARTY	. ,.				į		
1 11	PART II Other also Maria									
18	PART II. Other significant conditions			in the underlying	cause given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
ă		BRILLATIS				1 □ YES 2	NO	DF DEATH?		
Σ	DID TOBACCO USE CONTR	THROMBON			1010000000		•	1 TES 2 NO		
AN	25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE O		TH (Check only one)	UNCERTAIN	1 50				
PHYSICIAN: MEDICAL	EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:	5 Residence	6 ☐ Other (Specify)				
돑	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIN		JRY AT	28d. DESCRIBE HOW	NJURY OCCUP	RED		
BY	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆 Y	ES 2 NO					
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, atc. (Spec	— At home, ferm,	straet, fectory, office		281. LOCATION (Street of City or Town, State)	end Number or	Rural Route Number,		
PE	29e. CERTIFIER (Check only	CIAN: To the best of my know	ledge, death occurr	ed at the time, date	end place, and due	to the cause(s) and man	nner es stated			
NO.								euse(s) end menner es stated.		
BEC	29b. SIGNATURE AND THE OF CERTIFIC	della	M.	0	29c. LICENSE NUM	IBER	29d. DATE S	IGNED (Month, Day, Year)		
10 E	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF PE		~	D454	24	PAOL	4 27 95		
	MIZAR CHARAF				WPITAL,	GLEN' BUI	ente,	WD 21061		
	31. DATE FILEO (Month, Day, Year) AUG 01 19	32. REGISTRAR'S SIGN	ABURE Rarda	Ц						
الــــا	LOUOT 13	J# []								



be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must

COMPLETED

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Could not be

Nomicide

3 Suicide

								9	5	231	12
	REGISTRAR			RTMENT OF	HEALTH AND	MENTA	L HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last) Frank Starks					Ju	ly 26		43	9:15	PM
	250-10-0282 15km 2 □ F	6. AGE (In yrs. les	YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	0 ^{Mon}	of BIRTH	3 S	°C'ar	colina	reign
TOR	99. FACILITY NAME (If not institution, give street and number) Liberty Medical Center RESIDENCE OF DECEDENT	-			or Location of timore	DEATN		9c. COUNTY	/ A	N	
DIRECTOR	MD . 106. COUNTY N/A		10c. CIT	ry, town on Loca Ba1	timore					d. INSIDE CITY LIMITS?	
FUNERAL	717 Druid Park Drive				21217			U	S.	T COUNTRY?	
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS OECEDENT FORCES? 12 IF YES, GIVE WA	YES 2 N	MED NO	If yes, s	CENDENT OF HISP pecify Cuben, Mexic S 2 K NO Spec	cen, Puerto	N? (Specify Yee Rican, etc.)	or No-	Black, W Specify:	American India Thite, etc.	ın,
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th 0 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Merchant Marine 16b. KIND OF BUSINESS/INDUSTRY Shipping										
BE CON	17. FATNER'S NAME (First, Middle, Lest) Unknown				18. MOTHER'S N						
5	190. INFORMANT'S NAME (Type/Print) Frank Starks Sr.				and Number or Rura					.C.200)17
	20e. METNOD OF DISPOSITION THE Burlet 2 Cremetton 3 Removal from State 4 Donetton 5 Other (Specify)	20b.PLACE A cemetery, cree Garr	noatory or o		t Vet.	8/2/	ATE 20c. LOCATION — City or Town, State 0/95 Owingsmills, MD.).
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	CFSP	#28		ND ADDRESS OF F					onroe . 2121	
	23. PART I. Enter the diseases, or compilications that shock, or heart feilura. List only one ceus IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	tatic	Pro	state	Carci	now		atory arres	t,	Approxima Interval Be Onset and	tween
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
PHYSICIAN: MEDICAL CE	Hypertension 1 yes 2 pho pr									RE AUTOPSY FIN NILABLE PRIOR T MPLETION OF CO DEATN? YES 2 N	AUSE
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN S 25. WAS CASE REFERBED TO MEDICAL 28. PLACE OF DEATH (Check only one)											
IYSIC	EXAMINER? 1 YES 2 NO HOPPITAL: 1 Inpatient 2	ER/Outpetient 3	□ DOA	OTHER:	ne 5 🗆 Reeldence						
27. MANNIÉR OF DEATH 1 Natural 5 Pending 2 Accident Investigation 280. DATE OF INJURY (Month, Day, Year) 280. DATE OF INJURY (Month, Day, Year) 280. TIME OF INJURY AT WORK? 1 YES 2 NO 280. DESCRIBE HOW INJURY OCCURED											

28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)

28d. DESCRIBE HOW INJURY OCCURED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and menner ee stated.

2 ___ MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

此皿 M.D. 29c, LICENSE NUMBER 041365

29d. DATE SIGNED (Month, Day, Year) July 26, 1995

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type. Print)
GEORGE E. WICKS III M.D. 2600 Liberty 21216 31. DATE FILED (Month, Day,

32 REGISTRAR'S SIGNATURE BUCA TROP

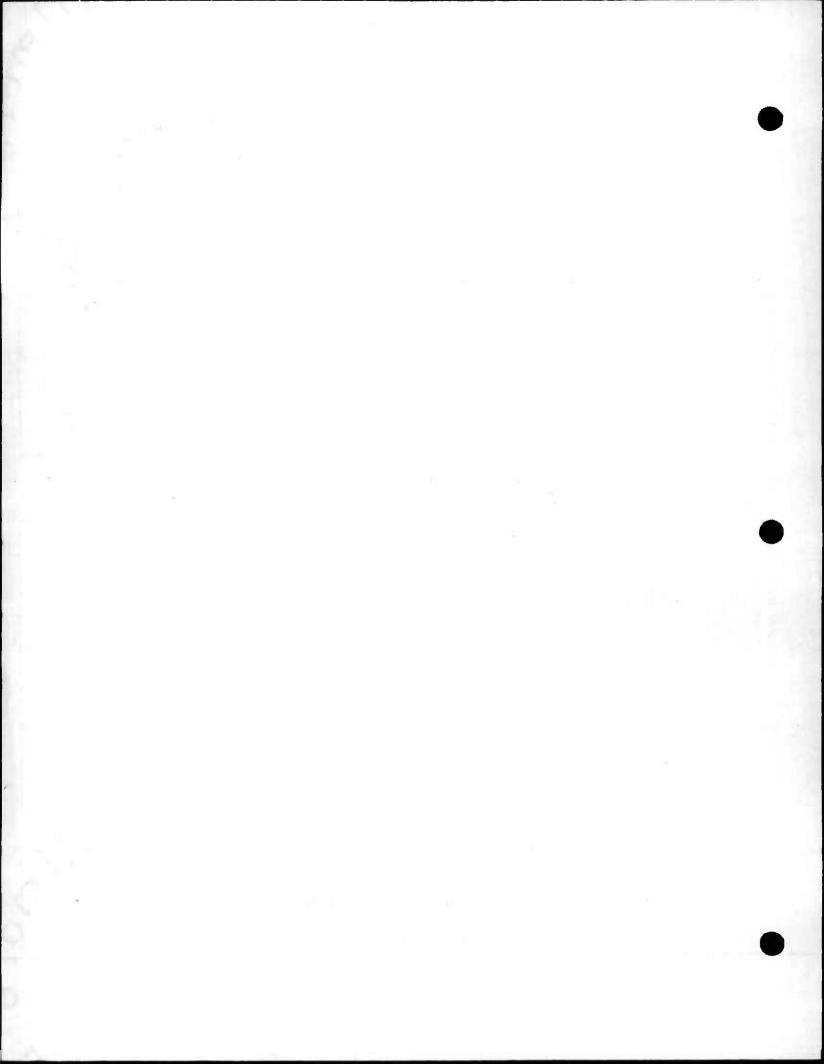
. .

		FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	MENT OF H	HEALTH AND	MENTA	L HYGIEN			
	8	1. DECEDENT'S NAME (First, Middle, Last) ALTON	L. Smit	Lh ,sr.			2. DATE OF DEATH DAY JOHN 3. TIME OF DEATH				
Þlí		4. SOCIAL SECURITY NUMBER 213-09-1614	1 🖾 M 2 🗆 F		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATI (Mor OCt	of BIRTH ith, Day, Year) .8,191		BIRTHPLACE (State or Foreign Country) [aryland	
, 2, 3 should	стов	NOCHA ARMO RESIDENCE OF DECEDENT	le/Hospith	4/ 6	den	BURN,	EATH		ANNE	EAMNE	
permit, Pages 1,	DIRE	10e. STATE 10b. COUNT	Arundel		own or Local dena	TION				10d. INSIDE CITY LIMITS? 1 YES 2 NO	
- S	FUNERAL	100. STREET AND NUMBER 153 Long P	t. Court		10	21122				N OF WHAT COUNTRY? J.S.A.	
215-0020 attending physician. se as the burial-transit	BY FU	11. MARITAL STATUS 1 Never Merried 2 Nerried 3 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 (29NO	If yes, sp	ENDENT OF HISPA ecity Cuban, Mexic 2 NO Specia	n, Puerto	N? (Specify Ye Ricen, etc.)	e or No— 14	Black, White, etc. Specify hite	
21 21 21 20 10 10	COMPLETED	15. DECEDENT'S EDU (Specify only highesi grade Elementary/Secondary (0-12)		18e. DECEDENT'S USU (Give kind of work life. Do NOT use re	done during mo tired.)	ON sst of working			SINESS/INDUS		
YLAND 2. by the hospital of the detached for all once.	OMP	17. FATHER'S NAME (First, Middle, Last) William S		Painter		18. MOTHER'S NA Lillia			mploye	ed	
3 A A	BE	WIIIIAM S	405 MAN THE ATT								
E, MAR y be retained y be retained bage 5 should be notified	5	Miss Janet Smi	th	7931 C	hesape	ake Dr.P	Route Nur lasad	ena Mo	m, State, Zip Co	. MD. 21226	
ALTIMORE, I seath. Page 6 may be funeral director, page 8 xaminer must be r		20a, METHOD OF DISPOSITION 1 ☑ Burlal 2 ☐ Cremetion 3 ☐ Rem 4 ☐ Donatton 5 ☐ Other (Specify)	oval from State Cam	PLACE AND DATE OF D	nlecel		DA 20	100		or Town, State	
BALTIMO after death. Page 6 by the funeral director moval. cal examiner mu		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	/	22. NAME AF	of Address of FA	CILITY		Daicin	ore, Ma. 21229	
E > E		23. PART I. Enter the diseases, or	complications that caused	the death. Do not	3204	Mountai	n Rd	.Pasad			
hours ed in or r		shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition	List only one cause on ea	ach line.			00 001		natory erres	Approximate interval Between Onset and Death	
ted within 24 completely fille ial, cremation, event, the		resulting in desth)	End-Stay	CONSEQUENCE OF): PUIWM	MIC (Spotruct	rve	HOIM	onary	e.	
	NO	Sequentially list conditions, if sny, leading to immediate	b	CONSEQUENCE OF):	wha						
O. BOX 68 ertificate be execut ng physician and c giene prior to buria	FICAT	cause. Enter UNDERLYING CAUSE (Disease or Injury C. Smoking									
U. 5 By P	CERTIFICATION	thet initiated events resulting in death) LAST	d	CONSECUENCE OF).							
RDS at the d by the and Mei		PART II. Other eignificant condition	s contributing to deeth be	ut not resulting in th	ne underlying	g ceuse given in	Part I.	24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO	
w requires that been signed I pt. of Health a shows any	MEDICAL							1 🗌 YES 2	NO	OF DEATH? 1 YES 2 NO	
AL has has Depr	PHYSICIAN:	DID TOBACCO USE CONTI		PLACE OF DEATH (C		UNCERTAI	Ν□				
F VITA SICIAN: The certificate h the State I , or Item	IYSIC	EXAMINER?	HOSPITAL:	itlent 3 DOA 4		e 5 🗆 Residence	8 🗆 Oth	er (Specify)			
PHY The state of t	ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	WO	URY AT RK? 'ES 2 NO	28d. DE	SCRIBE HOW I	NJURY OCCUR	ED	
TISIC TTENDI CTOR: A after da	ETED 8	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At home, ferm, strast, fectory, office building, etc. (Specify)					Rural Route Number,			
H H N H	COMPL		CIAN: To the best of my knowle R: On the basis of examination							ause(a) and menner ee stated.	
TO THE HOSPIT TO THE FUNERA DE filed within 7	TO BE (200 SIGNATURE AND TOTLE OF CERTIFIER	MD			D46	BER 1.	5	PUT SI	GNED (Month, Day, Year) - 1995	
5+1		YURI CABAL	ERO, 16	ARTEX	CIRCL	E #5	13	Owin	os M	ils, HD 21117	
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last)

)		ROSEMARY 4. SOCIAL SECURITY NUMBER	GARRIGAN 5. SEX 6. AGE	-	EITLE			9 1995	3.18 pm M	
_		215-09-5374	1 M 2 X F	80 1	thday) IF UNDER 1 YE WONTHS DA		Month, Day, M Aug. 25	, 1914	n. BIRTNPLACE (State or Foreign Country) Maryland	
2, 3 should	POR	9a. FACILITY NAME (If not institution, give at Saint Joseph Media	11 10-00.			WEOR, MERY	EATH	9c. COUNT	ry of DEATH	
physician, burial-transit permit, Pages 1,	DIRECTOR	nesidence of decedent 100. STATE 100. COUNTY Maryland Balti		10	Baltin				16d. INSIDE CITY LIMITS? 1 YES 2 X NO	
i. Insit perm	FUNERAL	100. STREET AND NUMBER 7116 Oxford Road				10f. ZIP CODE 21212			EN OF WHAT COUNTRY?	
	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	2 XNO	ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify, Cuben, Maxican, Puerto Rican, etc.) 1					
the hospital or attending detached for use as the once.	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 12 years	CATION completed) College (1-4 or 5+)	(Give ki	ENT'S USUAL OCCUP find of work done during NOT use retired.)	ATION g most of working	186. KIND O	F BUSINESS/INDU	white	
# € €	ш	17. FATHER'S NAME (First, Middle, Last) Joseph Francis	Garrigan	Home	marter		ME (First, Middle, M L. Care	alden Sumame)		
y be retained by sage 5 should be be notified at	TO B	Patricia S. Jaumo 204, METHOD OF DISPOSITION		223	0 Pleasar	eet and Number or Aural It Vue Circ	Route Number City o	ov Town, State, Zip C tsburgh,	PA 15241	
hours after death, Page 6 may be ed in by the funeral director, page or removal. medical examiner must be a		Suriel 2 Cremation 3 Ramo Donetion 5 Other (Specify)	wal from State	ob. PLACE AND Unetery, cremato	DATE OF DISPOSITION OF PURPLE DISCO VALLEY 22. NAM	Mem. Gdn's	8/1	c. location — ci	ty or Town, State , Maryland	
rs after death, Pag of the funeral dir removal.		hans	ough Bo	ser	1 650	chell-Wied	Dollar	3.70	01.01.0	
within 24 pletely fill cremation,	7	23. PART I. Enter the diseases, of cahock, or haert failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	Let only one ceuse on ARTERIOS DUE TO (OR AS	eech line.	IC CARDIO			respiratory arrei	Approximate interval Between Onset and Daath	
th certificate be ending physicia I Hygiene prior or other trau	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS							
requires that the death neen signed by the atte. of Health and Mental shows any injury, (MEDICAL C	PART II. Other significant conditions	contributing to death	but not reaul	iting in the underl	ying ceuse given in	PE	IS AN AUTOPSY REFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?	
law ept.		DID TOBACCO USE CONTR	IBUTE TO CAUSE (YES NO		10		1 ☐ YES 2 ☑ NO	
SICIAN: The laver certificate has the State Deptem 23 or Item 23	IYSICIAN	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL:	Ipatiant 3 🗆 0	OTHER:	Nome 5 🗆 Residence	a Other (Specify)		
DING PHYSI After this c death with s marked,	ВУ РНҮ	1 Netural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)		M 1	INJURY AT WORK?	28d. DESCRIBE N	OW INJURY OCCU	RED	
L OR ATTENDING F DIRECTOR: After thours after death item 28 Is mar	ETED	3 Suicide a Could not be determined	28s. PLACE OF INJUR building, atc. (Spe	Y — At home, 1	larm, atreet, factory, o	iffica	281. LOCATION (S City or Town,	treet and Number or State)	Rural Route Number,	
E SC =	COMPLE		IAN: To the best of my know						cause(s) and menner as stated.	
TO THE HOSPI TO THE FUNEF De filed within IMPORTANT:	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	Harinh m	٠٥.		29c. LICENSE NUM D 42723		29d. DATE 5	SIGNED (Month, Pay, Year)	
		30. NAME AND ADDRESS OF PERSON WHO AVVERAHALLI M. HA	ARISH M.D. 8	745 FO		REAM RD.	BALTIMO	RE MARYL	AND 21236	
		31. DATE FILED (Month, Day, Year) AUG 0 1 1995	32. REGISTRAR'S SIGN	NATURE	4					



30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Melten Tunchilek, M.D.

31. DATE FILED (MOD

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Pages 1, 2, 3 should permit. been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit and Mental Hygiene prior to burial, cremation, or removal. hours after death. Page 6 may be retained by the hospital or attending physician. notified at once. pe must examiner injury, or other traumatic event, the medical OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within shows any this certificate has been with the State Dept. item 23 10 marked, After t 69 DIRECTOR: A 28 hours

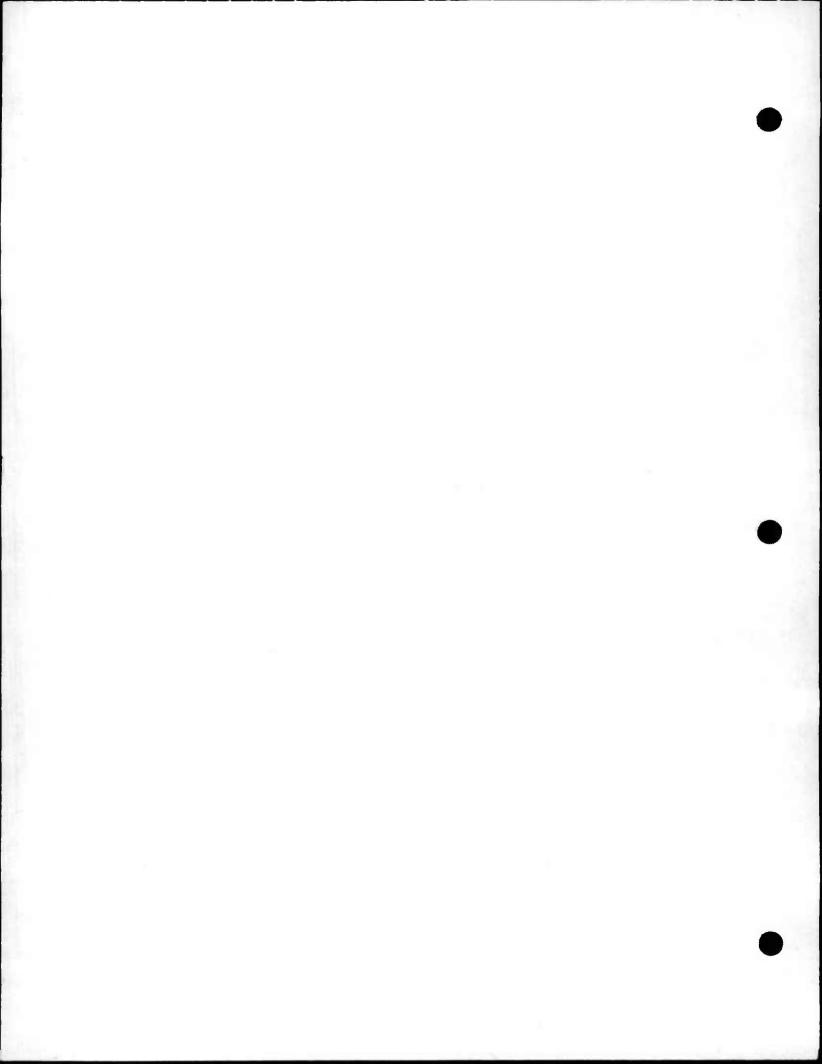
ITEM: 9c.15. PER F.H. FILM G-727 9/14/95 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT NAME (First, Middle, Last) 2. DATE OF OEATH 1956 4:30 A JULY 30 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. DATE OF BIRTH 1930 8. BIRTHPLACE (State or Foreign 1 🗆 H 2 🔀 YRS. 9b. GITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR more N/A 10c CITY TOWN OR LOCATION 10d. INSIDE CITY YES 2 NO STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 370 Kil 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yaa or NoIf yes, specify Cuben, Maxican, Puarto Rican, etc.)
 U YES 2 NO Specify: American Indian, White, atc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ary (0-12) College (1-4 or 5+) N/A 17. FATHER'S NAME (First, Middle, Last) BE 19a. INFORMANT'S NAME (Type/Print) 9 METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION 2 Cre 3 🗆 nation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Betts 23. PART i. Enter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory errest. Approximate shock, or heart fellure. List only one cause on each line interval Between IMMEDIATE CAUSE (Final Onset and Death diseese or condition resulting in deeth) Gastrointentna Upper hours OUE TO (OR AS A CONSEQUENCE OF): sseminated 25 hours CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING exastasis CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events recuiting in death) LAST conces PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE netastosis 1 TYES 2 NO DE DEATH? (Ucxillar orter 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES INO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINET? HOSPITAL:
1 V Inpetient 2 - ER/Outpetient 3 - DOA OTHER: 4 Nursing Home 5 Rasidence 6 Other (Specify) 27. MANNER OF GEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO ВУ 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER 1 PCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL D DE filed within 72 ho (Check only one) ination and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(s) and mannar as stated. 296. SIGNATURE AND TITLE OF 29c. LICENSE NUMBER 29d. DATE SIGNED (Mgnth, Day, Year) BE .D. AT 2438946 D7/30/95 2

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

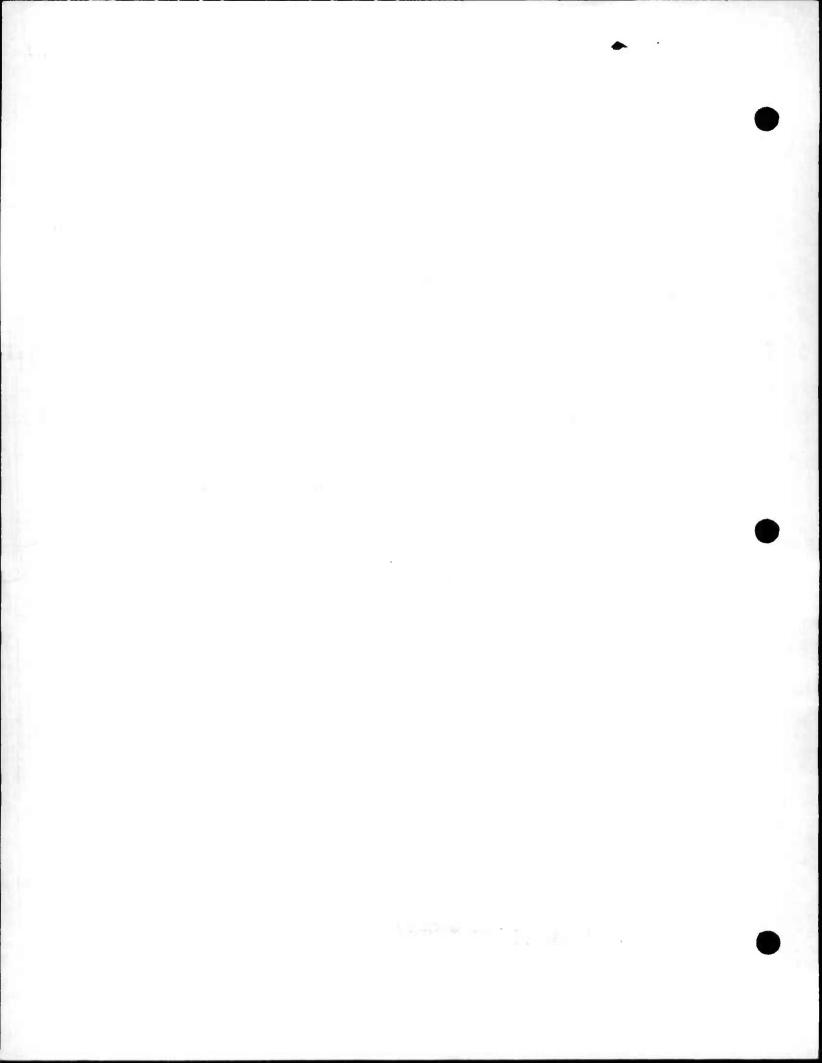
		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPA	RTMEN	OF H	EALTH /	AND W	IENTAL HYGIEN			
		1. DECEDENT'S NAME (First, Middle, Last) MACSHALL A-	SHAN							MAY - 9	YEAR	3. TIME OF DEATH
Þin		4. SOCIAL SECURITY NUMBER 219-53-7164	5. SEX 6. AGE (1)	n yrs. last birthday) IF UNDER	1 YEAR DAYS	IF UNDER 2	4 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year),	c 2	Country)	LACE (State or Foreign
2, 3 should	TOR	99. FACILITY NAME (If not institution, give s WM M RESIDENCE OF DECEDENT	treet and number)				more	N OF DEA	XTH	9c. COUN	Y OF DE	ATH
020 physician. burial-transit permit. Pages 1, 2,	DIRECTOR	100. STATE 100. COUNT Maryland Carro			stmin		ION	-			- 1	10d, INSIDE CITY LIMITS? 1 YES 2 NO
nsit perm	FUNERAL	100. STREET AND NUMBER 660 Geneva Drive					. ZIP COOE	157		10g. CITIZ	EN OF WH	IAT COUNTRY?
YLAND 21215-0020 by the hospital or attending physician. be detached for use as the bunal-tran	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	1	If yes, sp	ENDENT OF	HISPANI Mexican,	C ORIGIN? (Specify Ye, Puerto Rican, etc.)	s or No—	4. RACE - Black, Specify	- American Indian, White, alc. White
D 21215 pital or atten	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) Cotlege (1-4 or 5+)	(Give kind of work done during most of working life. Do NOT use retired.)				18b. KIND OF BU				
IARYLAND tained by the hospital should be detached titled at once.	ш	17. FATHER'S NAME (First, Middle, Last) Andrew Shaw						Real E (First, Middle, Maiden Anzolawi		0		
≥ 5 5 E	TO B	19a. INFORMANT'S NAME (Type/Print) Andrew Shaw					nd Number o	r Rural Ro	minster.	vn, State, Zip C		
LTIMORE, ath. Page 6 may be meral director, page aminer must be		20e. METHOD OF DISPOSITION 1	oval from State 20b.	PLACE AND OAT	E OF OISPOS	ITION /Ne		wesc		CATION — CI	ty or Town	
e de de		21. SIGNATURE OF PUNERAL SERVICE LIC	ENSEE Ronald W	ade, Di	2	State	2 Anal	tomy	Board-65 ore, Mary	5 W. E	alti	more Stree
within 24 pletely fill cremation.		IMMEDIATE CAUSE (Finel	complications that caused List only one cause on each cause on each cause on each cause on each cause on each cause on each cause on each cause of the cause of the cause of the cause of the cause of the cause of the cause	ch line.	not enter	the mo	de of dying	g, such	as cardiec or reep	iratory erre	et,	Approximate interval Between Onset and Death
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F = 9 -	CERTIF	thet initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):							=		
ORDS that the ced by the th and Me	EDICAL (PART II. Other significent condition	s contributing to deeth bu	it not resulting	in the un	derlying	; ceuse giv	ven in P	art I. 24a. WAS AN PERFOR	RMED?	A	/ERE AUTOPSY FINDINGS MAILABLE PRIOR TO OMPLETION OF CAUSE OF DEATH?
AL RECO e law requires th has been signed Dept, of Health	Σ	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF	F DEATH Y	ES 🗆 1	10 D	UNCE	RTAIN			1	YES 2 NO
VITAL CIAN: The lan ritificate has he State Dep or Item 23	HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Impatient 2 ER/Outpa	tient 3 DOA	OTHER	1:	5 🗆 Reek	dence 6	Other (Specify)			
이 중 등을 할	ВУ РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. OATE OF INJURY (Month, Dey, Year)	28b. TI		28c. INJU	JRY AT	:	28d. DESCRIBE HOW I	NJURY OCCU	RED	
S H D H S		3 Suicids 8 Could not be determined	28a. PLACE OF INJURY — At home, farm, streat, factory, office building, atc. (Specify)						ite Number,			
	COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINE	CIAN: To the best of my knowle	edge, death occur and/or investigat	red at the ti	me, date pinion, de	and place, a	nd dua lo	o the cause(a) and mar me, data and placa, an	nner as stated	cause(a) e	nd manner as stated.
THE F	TO BE (296, SIGNATURE AND TITLE OF CERTIFIES	Jus .				29c. LICENS 730		ER	29d. DATE 5	SIGNED (A	Aonth, Day, Year)
			VT NOMENTA	1	2	UTA	15 S	Γ.				
		AUG 1 1995	32. REGISTRAR'S SIGNA	TURE POLICE								



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CORDS, P.O. BOX 68760	res that the death certificate be executed within thours after death. Page 6 may be retained by the hospital or
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH 1995 24, 7:30 Helen Seiler July P M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 1 M 2 X F 214-12-8885 6/3/99 Μd 96 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATN DIRECTOR Arundel Convalencent Center Glen Burnie Anne Arundel 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Md <u> Anne Arundel</u> Glen Burnie 1 YES 2 1 NO use as the burial-transit permit. FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? West Furnance Branch Rd 21060 U.S.A. attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yea, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 215-0020 1 Never Married 2 Married ВY 1 YES 2 NO Specify. 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INOUSTRY (Specify only highest ō Elementary/Secondary (0-12) College (1-4 or 5+) detached Homemaker Home Once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) page 5 should be Ħ Edgar Pumphrev 띪 unknown notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Doris Biddinger Furnance Branch Rd., Glen Burnie, Md 21060 pe 26a. METHOD OF OISPOSITION
1 A Burlal 2 Crematton 3 Removat from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must OATE funeral director, Glen Haven Mem. Park 4 Donation 5 Other (Specify) 7/28/95 | Glen Burnie, Md examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ACCRESS OF FACILITY
McCully Funeral Home of Brooklyn Cuger n by the f removal. ac 237 E. Patapsco Ave. Balto., Md 21225 medical 23. PART i. Entar/tha diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arreat, filled in by 1 Approximate shock, or haart failure. List only one cause on each line. 6 intarvai Between IMMEDIATE CAUSE (Final completely filled nal, cremation, o Onset and Death injury, or other traumatic event, the disease or condition eu OUE TO (OR AS A CONSEQUENCE OF) resulting in death) 14200 physician and com ne prior to burial, week NO Sequantially list conditions, DUE TO JOH AS A COR by the attending physician are and Mental Hygiene prior to SEQUENCE OF if any, leading to immediata cause. Entar UNDERLYING CERTIFICAT CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? shows any signed Health a 1 TYES 2 PNO OF DEATH? requi DIVISION OF VITAL RE 1 YES 2 -NO t. of t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: Dept. HOSPITAL DR ATTENDING PHYSICIAN: The law 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate his Item EXAMINER? HOSPITAL: OTHER: 1 Inpatient 2 ER/Outpatient 3 DOA 6 the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) TIME OF 28c. INJURY AT this c 28d. DEŞCRIBE NOW INJURY OCCURED marked, 1_ Natural 5 Pending ВҰ 1 YES 2 NO After death 2 Accident Investigation 28 is 1 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: / COMPLETED 8 Could not be 4 Nomicide TO THE HOSPITAL DR AT
TO THE FUNERAL DIRECT
DE filed within 72 hours a
IMPORTANT: It Item 2 29a. CERTIFIER

(Chart and 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) 4000 ANNAPOCIS elimore 122 31. DATE FILED (Month, Day, Year)
AUG 0 1 1995



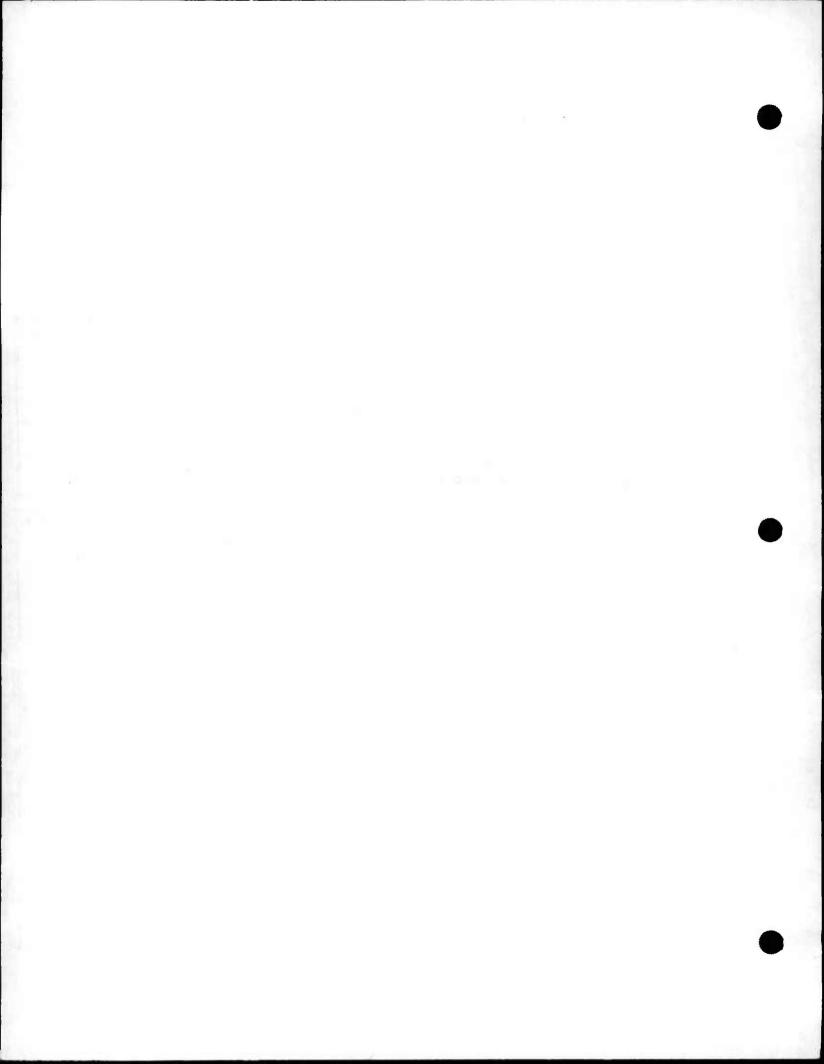
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remaind.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examinar must be notified at once.
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95 23118 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1, DECEDENT'S NAME (First, Middle, Last)

CHEETHRA DUY 2 3) TIME OF DEATH 1995 447p HANEY ALEXANDREA 0 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 704-95 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State of Country) 1 M 2 X F Black 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH University of Maryland Baltimore

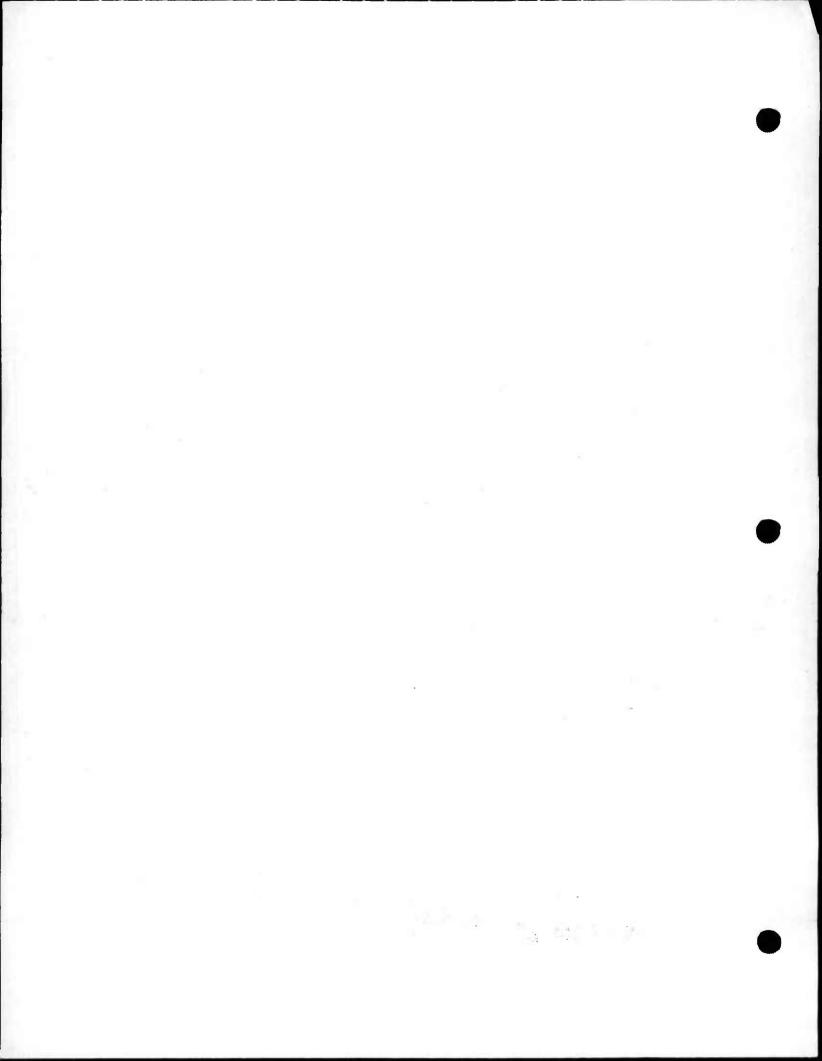
DIRECTOR	University of Maryland		Baltimore				
EC	10e. STATE 10b. COUNTY	10c. CITY, TO	. CITY, TOWN OR LOCATION 10d. INSIDE CITY				
H	Maryland Anne Arundel	Glo	n Burnie		LIMITS? 1 YES 2 NO		
	10e. STREET AND NUMBER	- Oce	101. ZIP CODE		10g CITIZEN C	OF WHAT COUNTRY?	
FUNERAL	401 Secret Bend		21060			or man occurrent	
S	11. MARITAL STATUS 12. WAS DECEDENT EVER IN I		13. WAS DECENDENT OF HISP	ANIC ORIGIN? (Specify Yes	or No.— 14. R	ACE — American Indian,	
В	1 Never Married 2 Married FORCES? 1 YES 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DAT		If yes, specify Cuben, Mexic 1 YES 2 NO Speci	cen, Puerto Rican, etc.)	8	Black, White, etc.	
딢	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEOENT'S USI	UAL OCCUPATION done during most of working	16b. KIND OF BU	SINESS/INDUSTR	Y	
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use re	tired.)			74.31	
ŏ	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S N	AME (First, Middle, Maiden	Sumame)		
ш			Rita.	Scott			
TO B	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING AD	DRESS (Street and Number or Rura	I Route Number, City or Tow	n, State, Zip Code,)	
ř	Rita Scott	401 Sec	ret Bend-Glen	Burnie, Ma	ryland	21060	
	20e. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Removal from State comet	PLACE AND DATE OF D	ISPOSITION (Name of		CATION — City o	r Town, State	
	4 - Donation 5 - Other (Specify) in state remova	tery, crematory or other	place)				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE RONALD WO	de, Dir.	22. NAME AND ADDRESS OF F	ACILITY DOG NO. (E.E.	W Pal	timore Street	
	Manual Allace	C	Rm.B-026-Bal				
	23. PART I Enter the diseases, or complications that caused to	the death Do not					
	snock, or heart failure. List only one ceuse on each	ch ilne.	onter the mode of dynig, so	cii ea ceidiec or respi	ratory strest,	Approximate Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition		2 - hts 0 0	· M'a		Onset and Death	
	resulting in death) aa.	TIZING Y	INTE ROCUL	1713	1-1		
_	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):						
ō	Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF)						
Ä	cause. Enter UNDERLYING PROCESSION CONTROL STROL STROL STRONG STROL STRONG STROL STRONG STROL STRONG STRONG STROL STRONG STRONG STRONG STRONG STRONG STRONG STRONG STROL STRONG ST						
Ħ	CAUSE (Disease or Injury that initiated events	CONSEQUENCE OF):	13.00				
H	resulting in death) LAST	LEME	PREMATO	BRITY			
PHYSICIAN: MEDICAL CERTIFICATION				,			
¥.	PART II. Other significent conditions contributing to death but	t not resulting in ti	he underlying cause given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
ă				1 _ YES 2	□ NO	COMPLETION OF CAUSE OF DEATH?	
Z		··- <u>·</u>				1 - YES 2 - NO	
Ž.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF			IN 🗆			
2	EXAMINER? / HOSPITAL:	B. PLACE OF OEATH (C	Check only one)				
YS	1 YES 2 NO 1 Inpatient 2 ER/Outpet	lient 3 DOA 4	☐ Nursing Home 5 ☐ Residence	6 Other (Specify)			
표	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF	WORK?	28d. DEŞCRIBE HOW II	NJURY OCCURED		
Β¥	2 Accident Investigation		M 1 YES 2 NO				
	3 Suicide 6 Could not be 4 Homicide determined	– At home, ferm, stree /)	t, factory, office	28f. LOCATION (Street (City or Town, Stete)	and Number or Rui	ral Route Number,	
집	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowled	dge, death occurred at	the time, date end place, end du	e to the ceuse(s) end mer	mer es atated.		
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of examination e					se(s) end menner ee stated.	
	286. SARNATURE AND TITLE OF CENTIFIER	110	29c. LICENSE NU	MBER	29d. DATE SIGN	IED (Month, Day, Year)	
BE	angen m lasty	MD	D464	95		120,1995	
임	30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type, Prin	10)	1		7 00/	
				0 3	/		
-	Angela MtaHerson 20	& South	h Greene	Stree	+		
	Aug 1 1995 Aug 1 1995 Aug 1 1995		h Greene	Stree	+		



DIVISION OF VITAL RECORDS, P.O. BOX 68760

HYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	d once.
e 6 may be retained	ector, page 5 should	must be notified
ours after death. Pag-	in by the funeral dir or removal.	medical examiner
ate be executed within 24 h	is certificate has been signed by the attending physician and completely filled in by the fith the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.	ted, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
nat the death certifical	I by the attending ph and Mental Hygiene	ny Injury, or other
AN: The law requires the	tificate has been signed s State Dept, of Health	r item 23 shows a
ATTENDING PHYSICI,	RECTOR: After this cert ars after death with the	m 28 is marked, o
TO THE HOSPITAL OR ATTENDING PHY	TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death with	IMPORTANT: If Item 28 is marke

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATN
	Oscar	SMITH			July 28	W YE	8:15 pm. M
	4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs. last bir	A P	IRTHPLACE (State or Foreign			
	410-07-1064 1X M 2 E		YRS. MONTHS DAY	8 HOURS MIN.	Juner, 19	TO T	ennessee
~	9a. FACILITY NAME (If not institution, give street and numb		9b. CITY, TOV	N OR LOCATION OF OEA		9c. COUNTY	OF DEATN
<u>ē</u>	Franklin Square Ho	Spital		Rossvill	e	Dalti	ore County
E I	10e. STATE 10b. COUNTY	1	0c. CITY, TOWN OR LO	CATION			10d. INSIDE CITY
<u>a</u>	Md. Balti	more		White	e Marsh		LIMITS?
M	10e. STREET AND NUMBER			101. ZIP COOE			OF WHAT COUNTRY?
FUNERAL DIRECTOR	5809 Ebenezer F			21162			USA
5	11. MARITAL STATUS 1 Never Married 2 X Married FORCES	CEDENT EVER IN U.S. ARMET		ECENDENT OF NISPANIC	C ORIGIN? (Specify Yes	or No- 14. I	RACE — American Indian, Black, White, etc.
BY	3 Widowed 4 Divorced	GIVE WAR OR DATES		ES 2 X NO Specify:	, , , , , , , , , , , , , , , , , , , ,		SpecHy: White
	15. DECEDENT'S EDUCATION	16a. DECED	DENT'S USUAL OCCUP	ATION	16b. KIND OF BUS	UNESS/INDUST	
	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	fife Do	und of work done during NOT use retired.)	most of working			
MP	10th		Mechanio	!	Ma	rtins	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAME	E (First, Middle, Malden	Surname)	
BE	C.S. Smith				White		
5	19a. INFORMANT'S NAME (Type/Print) Myrtle Smith	19b. M	5809 Ebe	et and Number or Aural Ro	ad White	n, Stete, Zip Code MArsh	"Md.21162
	20a. METHOD OF DISPOSITION 1 ☑ Burlat 2 ☐ Cremetion 3 ☐ Removal from Sta		DATE OF DISPOSITION ory or other place)	(Name of	OATE 20c. LO	CATION — City	or Town, State
	4 Donation 5 Other (Specify)	Holly	Hill Ce	metery 7		Baltim	ore Md.
	21. SIGNATURE OF FUNERAL SERVICE LICENSES	11		ano address of Facilities Fun		e of	Essex
	1. Jerry Cor	nelly		Mace Ave			
	23. PART I. Enter the diseases, or complication shock, or heart failure. List only on-	e that caused the	. Do not anter tha	mode of dying, such	ea cardiec or respi	retory srrest,	Approximata
	IMMEDIATE CAUSE (Final	o cause on each and					intarval Batween Onset and Death
		In death) . Acute Myocardial Infarction					
	DU	JE TO (OR AS A CONSEQUE	NCE OF):				
o l	Sequentielly list conditions, DL	DUE TO (OR AS A CONSEQUENCE OF):					
¥	cause. Enter UNDERLYING						i l
Ĕ	trial difficulta averies	JE TO (OR AS A CONSEQUE	NCE OF):				
CERTIFICATION	resulting in death) LAST						_
	PART II. Other significent conditions contribution	ng to death but not reeu	iting in the underly	ing ceuee given in Pa	art i. 24a. WAS AN	AUTOPSY T	24b. WERE AUTOPSY FINDINGS
CAL					PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
					1 YES 27	NO	OF DEATN?
ž	DID TOBACCO USE CONTRIBUTE TO	CAUSE OF DEATH	YES NO	UNCERTAIN			1 TES 2 NO
Ŋ.	25. WAS CASE REFERRED TO MEDICAL	26. PLACE O	F DEATH (Check only o				
PHYSICIAN: MEDI	HOSFIIA	L: t 2 - ER/Outpetient 3 - (OTHER:	ome 5 - Residence 6	Other (Specify)		
표	(Mo	TE OF INJURY 26 orth, Day, Year)	Bb. TIME OF 28c.	NJURY AT 2 WORK?	28d. DESCRIBE HOW IN	JURY OCCURE	0
B	1 Natural 5 Pending 2 Accident Investigation			YES 2 NO			
윤	3 Suicide 6 Could not be 4 Homicide determined	ACE OF INJURY — At home, iding, atc. (Specify)	ferm, street, lectory, o	fics 2	261. LOCATION (Street a: City or Town, State)	nd Number or Ru	rel Route Number,
ון בַּ	29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the be	ent of my knowledge, death	nonumed of the time of				
COMPLETE	(Check only one) 2 MEDICAL EXAMINER: On the basis						se(a) and manner as stated.
H H	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUMB	ER	29d. DATE SIG	NED (Month, Day, Year)
<u>p</u>	100	_	MAD.	D17728		July	29 1995
-	Ba Yin Oung M.D. 8022			Md 21224			
		JEAN'S SICK THE A	Datcinole	FIG. 21230			
	AUG 0 1 1995	ATTENDED OF THE PERSON.					



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THE STATE OF THE S	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremati	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH Bernard Sprissler July 29, 1995 8:15 A M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 🔀 M 2 🗌 F 73 YRS 067-24-8875 May 1, 1922 Germany 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Stella Maris Hospice Towson Baltimore County RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Co. Baltimore 1 TYES 2 TO NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3707 Durley Lane 21207 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES If yes, specify Cuben, Mexicen, Puerlo Rican, atc.) 1 Never Married 2 X Married Specify: B 1 TES 2 NO 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Martin Marietta Elementary/Secondary (0-12) College (1-4 or 5+) years Senior Engineer Defense Industry 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Bernard Sprissler H Marie Laub 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Mrs. Mary A. Sprissler 3707 Durley Lane Baltimore, MD 21207 pe 20m. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must 1 Buriel 2 Tormation 3 Removal from State
4 Donation 5 Other (Specify) Carroll Cremation, Inc. 7-30 Hampstead, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD the medical 23. PARTY Enter the diseasea, or complications that caused the deeth. Do not enter the mode of dying, euch ee cerdiec or respiratory arrest, ahock, or heert failure. List only one ceuse on each line intervel Between IMMEDIATE CAUSE (Final Squamous Cell Onset and Death disease or condition resulting in death) Lung Cancer with Metastasis event, 4 Months DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially liet conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury Injury, or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? shows any 1 - YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN **PHYSICIAN**: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL: OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 8 🖾 Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, 1 X Natural 5 Pending M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) .09 COMPLETED 8 Could not be 4 Homicide 28 item 2 29a. CERTIFIER (Chack only 1 😾 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated. 2 MEDICAL EXAMINER: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner es stated. 29p. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 00 bellus DA5047

9 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Kendall Faulkner 31. DATE FILED (Month, Day, Year)
AUG 0 1 1995

2300 Dulaney Valley Rd. 32 REGISTRA'S SIGNATURE

7-29-95

21204

Towson, MD

BALTIMORE, MARYLAND

transit permit. Pages 1, 2, 3 should

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-24 hours after death. Page 6 may be in	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

AUG 01 1995

32. BEGISTRANS SIGNATURE Parkell

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	Items9b&22,g-726,8-	1-95, perf.h	h.,dk										
	1 - FOR STATE REGISTRAR	STATE OF M	ARYLAND /	DEPAR	TMENT	OF H	EALTH	AND I	MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)		TU						MON	E OF DEATH		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las			1 VEAD	IF UNDER	24 Hmc		Y 31,	1995	4. 81871	12:45 P M
	218-62-2981	%□ M 2 □ F	MONTHS DAYS HOURS MIN.					(Mon	th, Day, Year)	195	Countr	ARYLAND	
	9e. FACILITY NAME (If not institution, give street and number)				9b. CITY	, TOWN C	R LOCATI	ON OF DE				INTY OF D	
DIRECTOR	THE JOHNS HOPKINS HOSPITAL				BLAT	HMO	RE CI	TY	Balti	more Cit	y N	/A	
EC	10a. STATE 10b. COUNTY	,		10c. CIT	Y. TOWN C	OR LOCAT	ION						10d, INSIDE CITY
		/A			BAL			CIT	Y				LIMITS?
FUNERAL	10e. STREET AND NUMBER					101	. ZIP CODI	E			10g. CIT	IZEN OF Y	WHAT COUNTRY?
<u></u>	5412 RELCREST	ROAD AF	PT. A				2	1206	6		U.	S.A.	
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. AR	MED						N? (Specify Yea	or No-	14. RACE	E — American Indian, k, White, atc.
BY F	1 Never Married 2 Married	IF YES, OIVE WA	YES 2	NO			2 NO			Rican, etc.)		Speci	
	3 Wildowed 4 Divorced		7 - 500 50				X	.,,				Орос	BLACK
ENETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	/G	CEDENT'S	work done i	CCUPATIO	ON st of workin	g	16	b. KIND OF BUS	SINESS/INI	DUSTRY	
#E	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	. Do NOT us	se retired.)					DOMINI			
薯	11TH	N/A		C00	K					DONU	' SH	OP	
8	17. FATHER'S NAME (First, Middle, Last)	OWED								Middle, Maiden			
BE	MELVIN S. TU	CKER					G	RAC	IE]	ROGERS	5		
2	19e. INFORMANT'S NAME (Type/Print)									nber, City or Town			
-	GRACIE ROGERS			5412	REI	LCRE	ST	RD.	BAI	LTO,MI). 2	1206	5
	20a. METHOD OF DISPOSITION 1- Burlal 2 Cremation 3 Ramo	oval from Stata	20b. PLACE / cemetery, cre	metaniara	there alean!			7 4	1			City or To	
	2) SI NATURE OF FUNERAL SERVICE LIC		MT.	ZION	CEN	1ETE	ERY	/-4-	-95	BA	LTO	, MI).
	212 SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. C7	NAME AN	D ADDRES	S OF FAC	CILITY	tarvin b	- Scr	uggs I	HOME
	Cal Man Di	ACALL	DOD,	41	14	112	E.	PRES	STOI	N ST.	PIT	← N	MD. 21213
	23. PART i. Enter the diseases, or c	omplications that	caused the de	ath. Do r	not enter	the mo	de of dyl	ng, such	h as car	diec or reapi	ratory ar	rest,	Approximate
J	shock, or heert failure. I IMMEDIATE CAUSE (Finel	_ist only one caus	e on wech line),									interval Between Onset and Death
	disease or condition	DE	TROV	100	11	1	LLI	VEC	7				YOUR YOUR
	resulting in death)		OR AS A CONSE										1 THE YORK
z													
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEC	DUENCE O	F):								
2	CAUSE (Disease or Injury	à											
	that initieted events	DUE TO (OR AS A CONSEC	DUENCE O	F):								
ER	resulting in death) LAST	J											
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<u> </u>	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLAC	E OF DEAT	OTHER	_							
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ᇤ	27. MANNER OF DEATH 1 Vetural 5 Pending	28a. DATE OF II (Month, Day		28b. TIM INJ	E OF URY	28c. INJI WO	JRY AT RK?		28d. DE	SCRIBE HOW I	JURY OC	CURED	
B	2 Accident S Pending Investigation				М	1 🗌 Y		NO					
3 Suicida 4 Homicide 8 Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, office 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, desth occurred at the time, date end place, and dua								nd Number	or Rural R	loute Number,			
P	(Check only												
ō l	2 MEDICAL EXAMINER	t: On the beala of exa	imination and/or i	nvestigstio	n, in my o	pinion, de	sth occur	ed at the t	time, date	end place, and	d dua to th	te cause(e)	end manner as stated.
w II	296. SIGNATURE AND TITLE OF CERTIFIER	200	ma		1	,	29c. LICE	NSE NUM	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
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임	30. NAME AND ADDRESS OF PERSON WHO												
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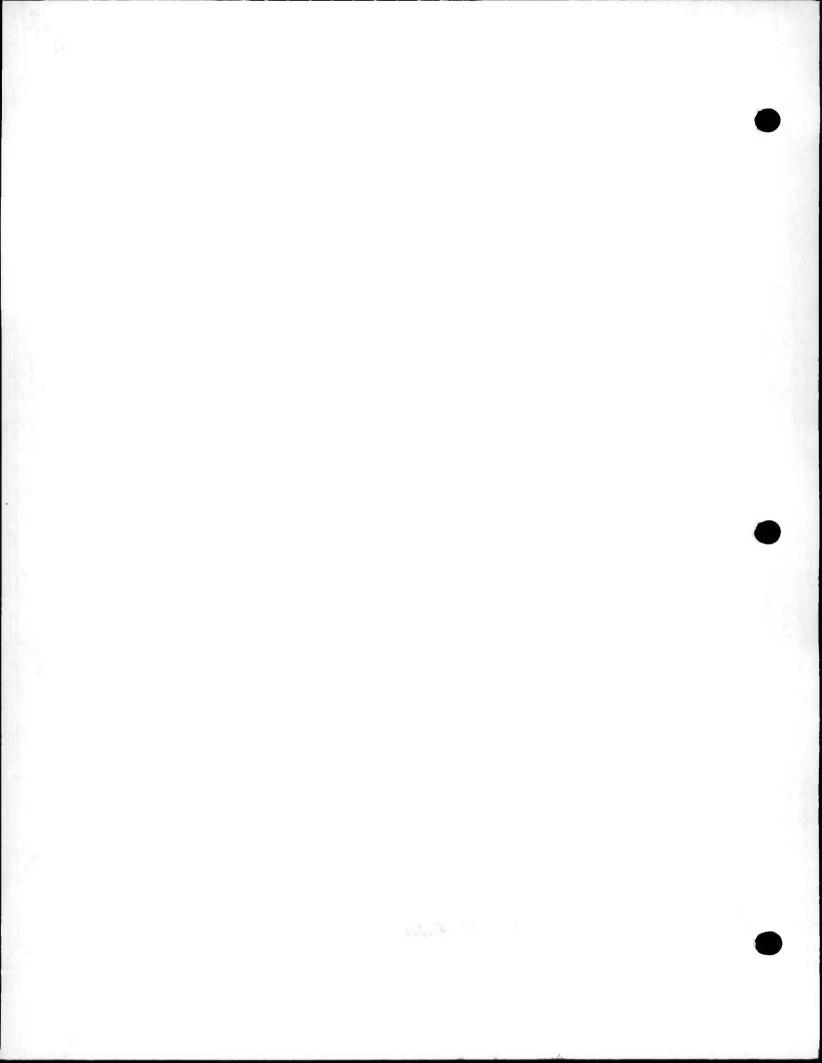
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CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH JULY 27 DAY 1995 YEAR EDIA TCHIT.AK 4:40 P 4. SOCIAL SECURITY NUMBER 5. SFX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year) 212-02-7457 HOURS 1 M 2 X F 77 YRS. OCT.24,1917 RUSSIA Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR JEWISH CONVALESCENT CENTER BALTIMORE BALTIMORE RESIDENCE OF DECEDENT 10b. COUNT 18c CITY TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD N/A BALTIMORE 1 YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3615 FORDS LANE use as the burial-transit 21215 **ISRAEL** the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THO IF YES, OIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married
3 Wildowed 4 Divorced В 1 TES 2 XNO Specify Specify: WHITE ETED. 15. DECEDENT'S EDUCATION tea. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade com the funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL HOUSEWIFE OWN HOME LINKNOWN 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) VAINBERG UNKNOWN notified at BORIS Page 6 may be retained by BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14312 FAIRDALE RD; SILVER SPRING, MD 20905 9 MRS. ADELA ZILBERBAUM pe 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Neme of 29c. LOCATION -- City or Town, State 1 N Buriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) must ARLINGTON-CHIZUK AMUNO 7-30-95 BALTIMORE, examiner SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 the medical 23. PARTI. Enter the diseases, or empiricatione that ceused the death. Do not enter the mode of dying, euch ea cardiac or reapiratory arrest, shock, or heart failure Liet only one cause on each line. and completely filled in by burial, cremation, or remo 0 Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in death) KIDNEY MALIGNANCY WITH METASTASES event. 3 MONTHS DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE DE): if any, leading to immediate attending physician cause. Entar UNDERLYING CAUSE (Diseese or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events reaulting in deeth) LAST Mental F signed by the a Health and Men PART II. Other algnificant conditions contributing to death but not resulting in the undariying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? PERFORMED? 1 - YES 2 - NO 1 YES 2 NO been : PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square Dept 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate I HOSPITAL: 1 TES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Nome 5 - Residence 8 - Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) this c 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked. 1 X Natural M 1 YES 2 NO В After death OR ATTENDING 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Sulcide 28 is ETED. 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be DIRECTOR: after 4 Homicide 29e. CERTIFIER COMPLI 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end menner ee stated.
2 U MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) end menner as stated. TO THE FUNERAL D be filed within 72 hr IMPORTANT: If it 296. SIGNATURE AND MILE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 JULY 29, 1995 2 30 NAME AND ADD WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) IAN SUNSHINE, MD 6210 PARK HTS. AVE, BALTIMORE, MD 21215 REGISTRATE SIGNATURE 31. DATE FILED (Month, Day, Year) AUG 0 1 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

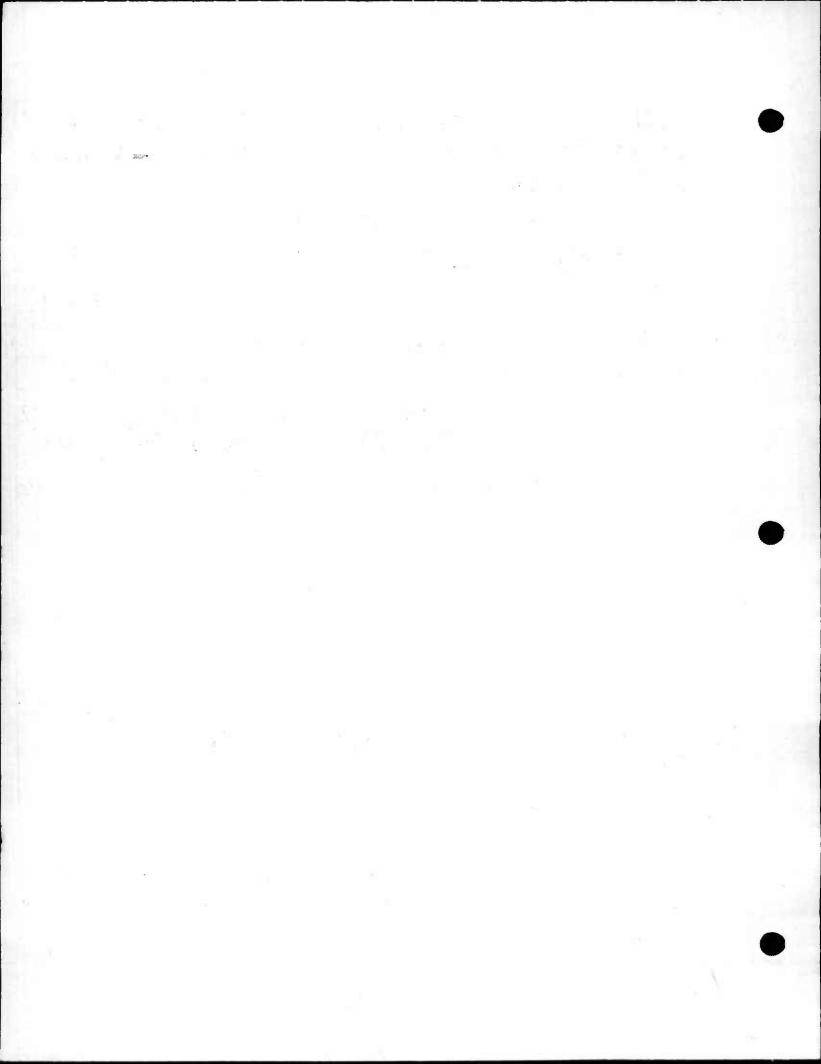
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ARU NDEMIA 8:00 17 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 213-38-2457 (Month, Day, Year) 8-26- 1. 1 M 2 💢 F JASH. Should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 of DIRECTOR FON APOLN HRUNDEL MEDICIR ARUNDEL ZIGING 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY EDGEWATER, MD ARKNASE 1 YES 2 NO FUNERAL 10e STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 63 (1DLAND KOAD 21037 USA within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexicen, Puerto Rican, atc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Merried B Specify: 3 Wildowed 4 Divorced WHITE 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 17045& 211=E DWN Hom 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surna 7 103204 41420 BE FRANCES notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 A 105817 Bo. FINDEWIA MIDLAND EDLEW ATTR. MD 021037 pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1 Suriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) LATDEBALLATION cemetery, crematory or other place)
Cedard Hill Cemetery 7/25 Suitland, examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A Ridgely Ave. Annapolis, MD 21401 event, the medical 23. PART I. Entar tha diseases, or complications that caused the death. Do not anter tha mode of dying, such as cardiec or reepiratory screet, filled in by shock, or heart feliure. List pnly one ceuse on each line. ŏ interval Between IMMEDIATE CAUSE (Final **Onset and Death** diseese or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): been signed by the attending physician and completely of Health and Mental Hygiene prior to burial, crematic POST OBSTRUCTIDE traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate CSUSA. Enter UNDERLYING Pro BABLE DUE TO (DR AS A CONSEQUENCE DF): Pir mo No CAUSE (Disease or Injury other thet initiated events resulting in death) LAST 6 Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? shows any 15 URU PTA 1 YES 2 NO HEONIC Eympita Desin 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: this certificate has be with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Item HOSPITAL: 1 TYES 2 DANG OR ATTENDING PHYSICIAN: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 9 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DEŞCRIBE HOW INJURY OCCURED marked, 11 Matural 5 Pending TO THE HOSPITAL OR ATTENDING PH TO THE FUNERAL DIRECTOR: After thi be filed within 72 hours after death w IMPORTANT: If Item 28 is mark 1 YES 2 NO BY 2 Accident 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Butunovcis, and MUTT 31. DATE FILED (Month, Day, Year) AUG 0 1 1995 REGISTRARIE SIGNAT



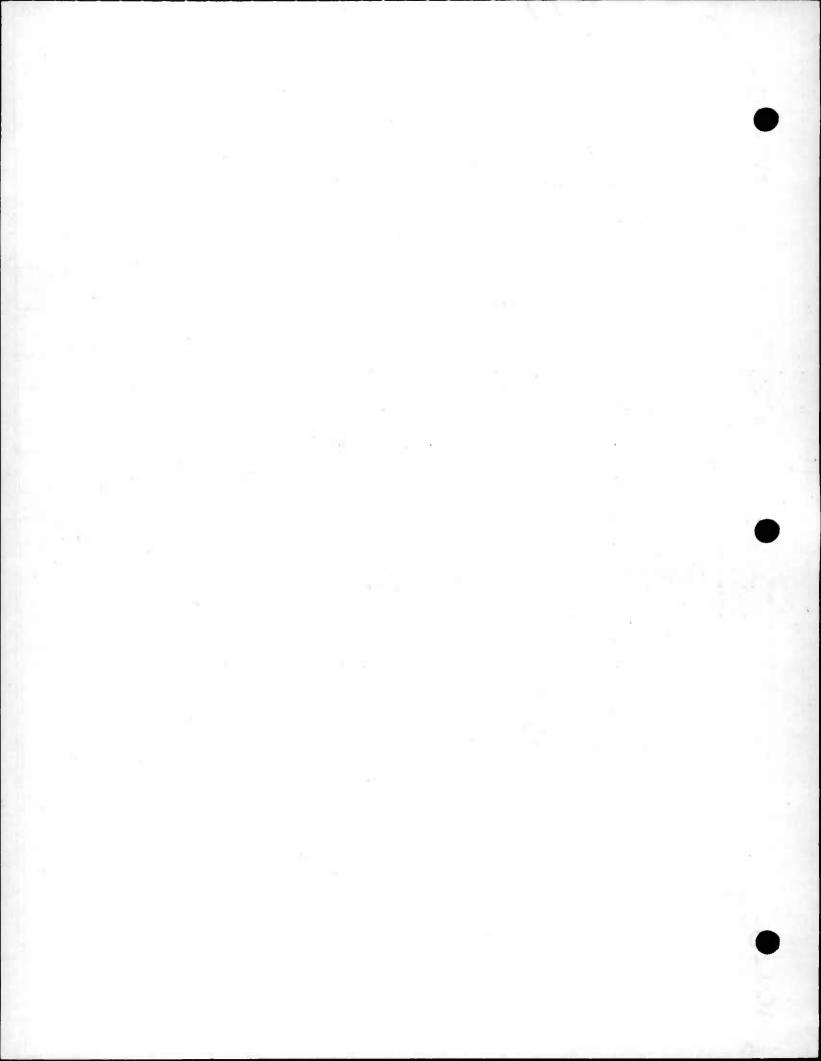
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2, 3 should	TOR	SOCIAL SECURITY NUMBER 18-03-0032 9a. FACILITY NAME (II not Institution, give str	9 Pearl Wi 5. SEX 6. AGE (In yrs. last birthday, 1 M 2 DF 80 YRS. Page and number). NUTSING HOME	F UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 9b. CITY TOWN OR LOCATION OF DE	PEATH 9c. COUNT	3. TIME OF DEATH S. BIRTHPLACE (State or Foreign County) Y OF GEATH TO OF GEATH
21.215-0020 or attending physician. Ir use as the burial-transit permit. Pages 1,	ETED BY FUNERAL DIRECTOR	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY 10e, STREET AND NUMBER 15. MARITAL STATUS 1 Newer Married 2 Married 3 Widowed 4 Divorced 15. OCCDENT'S EDUC (Specify only highest grade of the county of the cou	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES	If yes, specify Cybeth, Maxic 1 YES 2 NO Specify S USUAL OCCUPATION If work done during most of working	I 10g. CITIZE	10d. INSIDE CITY LIMITS? 1 PYES 2 NO EN OF WHAT COUNTRY? 14. RACE — American Indian, Black, White, etc. Specify: Black Stry AND 6 Warke
ALLIMONE, MARYLAND 2 death, Page 6 may be retained by the hospital e funeral director, page 5 should be detached for examiner must be notified at once.	TO BE COMPLET	17. FATHER'S, NAME (First, Middle, Last) 19. INFORMANT'S NAME (Tipe/Print) 20. METHOD OF DISPOSITION 10. Burlan 2 Cramation 2 Remont 1 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	Recre	IG ADDRESS (Street and Number or Rural Stamtora EOPPHPOSITION (Name of	CTO CTO AME (First, Middle, Melden Surname) 1	Md. 21229 By or Town, State J. Co. Md. al Hume
NDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after NDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after this certificate has been signed by the attending physician and completely filled in by the of death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removative marked, or item 23 shows any injury, or other traumatic event, the medical	CERTIFICATION	23. PART Enter the diseases, or contained the sease of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF A THE ROLL OF AS A CONSEQUENCE OF A THE ROLL OF AS A CONSEQUENCE OF A THE ROLL OF AS A CONSEQUENCE OF A THE ROLL OF AS A CONSEQUENCE OF A THE ROLL OF AS A CONSEQUENCE OF A THE ROLL OF AS A CONSEQUENCE OF A THE ROLL OF AS A CONSEQUENCE OF A THE ROLL OF AS A CONSEQUENCE OF A THE ROLL OF AS A CONSEQUENCE OF A THE ROLL OF A	C ARRHYTH OF: ARTINY OF: OF: OF: OF: OF: OF: OF: OF	MIA	Interval Between Onset and Death MCMUTES SEUCHAL TEAAS
	D BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 28e. DATE OF INJURY 28b. TII	ZES NO UNCERTAL ATH (Check only one) OTHER: 1 Nursing Home 5 Residence WORK? M 1 YES 2 NO	PERFORMEO? 1 YES 2 NO	
TO THE HOSPITAL DR ATTE TO THE FUNERAL DIRECTOR be filed within 72 hours afte	TO BE COMPLETE	29a. CERTIFIER (Check only 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER	AN: To the best of my knowledge, death occur On the basis of examination end/or investigati	ion, in my opinion, death occured at the	to the cause(a) and manner as stated at time, date and place, and due to the object. MBER 29d. DATE S A C	cause(s) and manner as stated. SIGNEO (Month, Day, Year) LGULT 1 - 95



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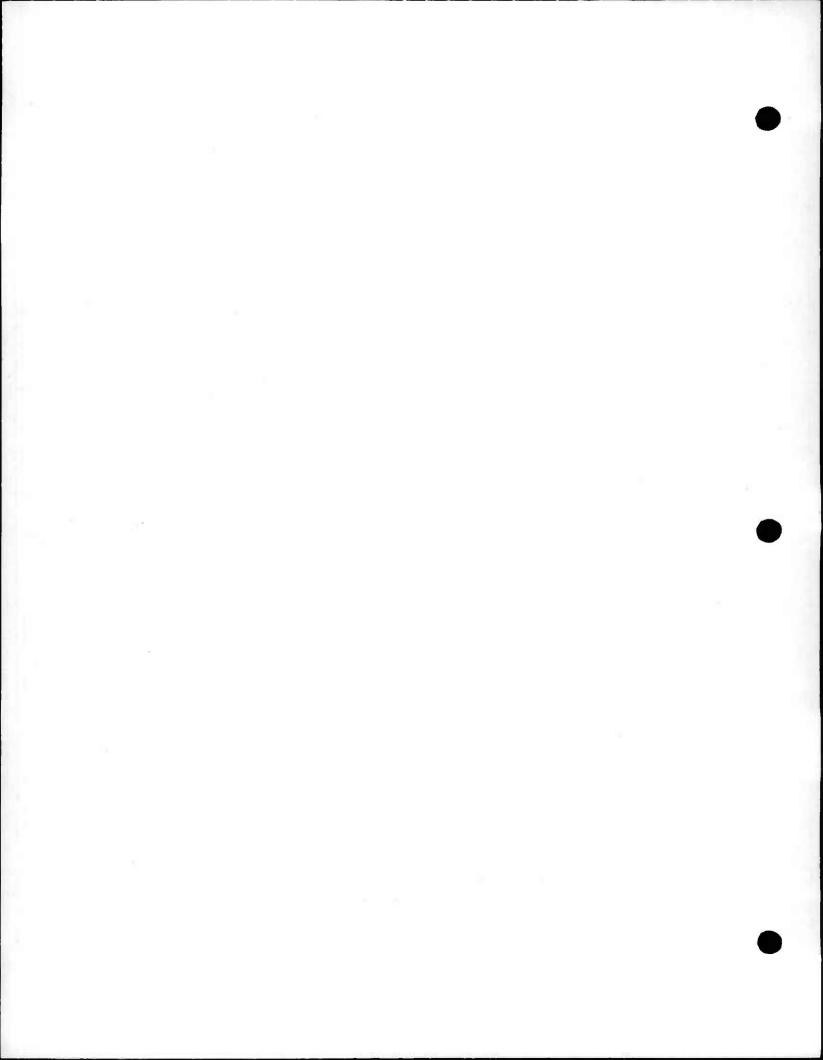
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATN 3 TIME OF OFATN YEAR OHN WILKINS SR JULY 30 1991 07:00 A M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 7. DATE OF BIRTN (Month, Day, Year) a. BIRTHPLACE (State or Foreign Country) 215 03 0650 DAYS HOURS 1 M 2 - F Oct. 17, 1915 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Harbor Hospital Center DIRECTOR **Baltimore** N/A RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Anne Arundel Baltimore permit. 1 YES 2X NO 10e. STREET AND NUMBER FUNERAL 101. ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? 6 First Avenue funeral director, page 5 should be detached for use as the burial-transit 21225 U.S.A. death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECENOENT OF NISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Maxican, Puerto Rican, stc.) 14. RACE — American Indian, Black. White, atc. **BALTIMORE, MARYLAND 21215-0020** 1 Never Married 2 X Married 1 YES 2 NO BΥ Specify: 3 Widowed 4 Divorced White World War II COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16h. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 7th Painter Domino Sugar Refinery 17, FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Alfred Wilkins Mary Nagel BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Sophie Wilkins First Avenue Baltimore, Maryland 21225 Pe 20a. METHOO OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata
4 Donation 6 X Other (Specify) Entombment **Must** Cedar Hill Cemetery 8/2 Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. momuneuron 4001 Ritchie Hwy. Baltimore, Md. filled in by the medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory erreat, Approximate shock, or heert failure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Deeth curunoma of the lung cremation, the state disease or condition DUE TO (OR AS A CONSEQUENCE OF): call completely event, resulting in death) ynknown and com traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated events attending resulting in death) LAST 6 the atten Mental PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS been signed by the AVAILABLE PRIOR TO Ischenic heart any disease Hypertension COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Shows 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has b. Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate t HOSPITAL: EXAMINER? OTHER:
4 □ Nursing Home 5 □ Realdence 6 □ Other (Specify) 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA the 27. MANNER OF DEATH 26s. DATE OF INJURY 26b. TIME OF INJURY 28c. INJURY AT 26d, DESCRIBE HOW INJURY OCCURED marked, with 1 Natural 5 Pending 1 YES 2 NO L DR ATTENDING P L DIRECTOR; After 1 2 hours after death BY 2 Accident Investigation 3 Suicida 28s. PLACE OF INJURY — At home, term, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 6 Could not be determined COMPLETED 4 Nomicide If item 29a. CERTIFIER (Check only one) 1 🗹 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. HOSPITAL FUNERAL I TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE Elotherais Mouse officer AS244161451 Medical ► July, 30, 1995 2 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 1eftheriadis Ivanam MD 3001 Sillanoverst. Bultimore Md 31. DATE FILED (Month, Day, Year)
AUG 0 1 1995 32. PEGISTRAR'S SIGNATURE



BALTIMORE, MARYLAND 21215-0020	4 hours after death, Page 6 may be retained by the hospital or attending physician.	IERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furnish director, page 5 should be detached for use as the burial-transit permit, Pages 1, in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	EFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the in 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	7. 16 than 600 to marked on the contract of th

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

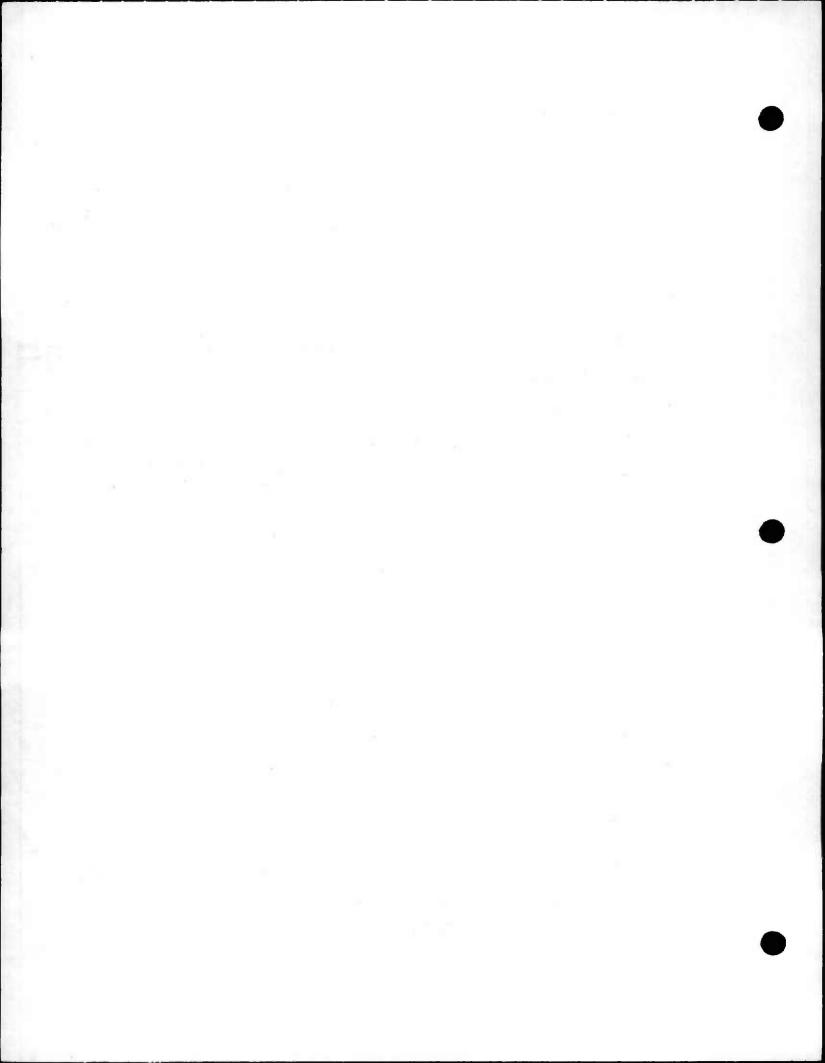
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r	9a. FACILITY NAME (If not institution, give				Carry, nown Balti	N OR LOCATION OF D	EATH		9c. COUNTY		Н	
DIRECTOR	2213 Westfield	Ave.			Dairi	lillore			IN/F	1		_
	10s. STATE 10b. COUNT		10-		WN OR LO					10	d. INSIDE CITY LIMITS?	
	Maryland 100. STREET AND NUMBER	N/A_		Bal	timor						YES 2 NO	_
FUNERAL		A				101. ZIP CODE					T COUNTRY?	
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	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 [If yes,	specify Cuban, Mexico ES 2 NO Specific	an, Puerto Ri	cen, atc.)		Bleck, W Specify:	hita, etc.	
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	15. DECEDENT'S EDU (Specify only highest grade	completed)	16a. DECEDE (Give kii life. Do f	ENT'S USU nd of work VOT use ret	done during	NTION most of working	16b. i	CIND OF BUS	INESS/INDUS	TRY		
COMPLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Floor					Lehow	Tailo	nrinc	1 (0	
	17. FATHER'S NAME (First, Middle, Last)		11001	Lady		18. MOTHER'S NA				JI THE	00.	_
	Joseph Donatelli					Maria	Mig	nini				
2	19a. INFORMANT'S NAME (Type/Print)		- 1			et and Number or Rural	Route Numbe	r, City or Town	, Statu, Zip Co	rde)	-	
_	Rose Marie Ward	King		ne as			-					
	1 ☑ Buriel 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	ioval from State	cemetery, cremator	y or other p	SPOSITION	th Cemeter	DATE	20c. LOC	Dalta			
	21. SIGNATURINOF FUNERAL SERVICE LI	CENSEE	<u>uaruer</u>	15 01	22. NAME	AND ADDRESS OF FA	CILITY		Balto.			_
	* Knold & Sela	lu sh.			5305	nard J.Ruc Harford	Rd R	alto	Md 2	1214		
	23. PART I. Enter the diseases, of shock, or heart failure.	complications that co	used the death. on each line.	Do not e	enter the n	mode of dying, aud	ch aa cerdie	c or reepi	ratory arrest	,	Approximate	
-	IMMEDIATE CAUSE (Finel									Onset and Deal		
	disease or condition resulting in death)	. Metastat	AS A CONSEQUEN	204	n ot	colon.					6 mor	
ا ہ	_	U saz io ia	NS A CONSCIDEN	CE OF):								
2	Sequentielly list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								-			
5	cause. Enter UNDERLYING CAUSE (Disease or injury											
ERTIFICATION	thet initiated events DUE TO (OR AS A CONSEQUENCE OF) resulting in death) LAST											
3		d										_
Ä	PART II. Other significant condition	s contributing to de	ath but not result	ting in th	e underly	ing cause given in	Part I. 2	4s. WAS AN A PERFORE			RE AUTOPSY FINDINGS VLABLE PRIOR TO	
EDICAL									MPLETION OF CAUSE DEATH?			
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
SICIAN:	25. WAS CASE REFERRED JO MEDICAL	KIBOTE TO CAUS	26. PLACE OF				ΝЦ					_
SIC	EXAMINERY	HOSPITAL:	VOutpatient 3 🗆 D		HER: Numbry H	ome 5 % Residence	6 □ Other /	Specify				_
	27. MANNER OF DEATH	28s. DATE OF INJ		TIME OF	25c. I	NJURY AT			HUNY OCCUR	60		-
	1 Feeding 5 Pending 2 Accident Investigation			11:50501005		YES Z NO						
	3 Suitcide 6 Could not be 280 BLACE OF INJURY — At home, farm, street, factory, office claremings determined building, etc. (Specify, office clayer liver, State)								Number.			
9									_			
MF	(Check only 1 Emptying Physician, To the best of my tage-fidge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the Design of Stamination and/or investigation, the manner as stated.											
3	296. SIGNATURE AND TITLE OF CERTIFIE				7.0.			To piece, and				_
	296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE BIONED (Month, Day, Yakr)							75				
2	36. NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE O	OF DEATH (ITEM 37)	(Type, Print	y .	7.07			()	1		-
	Marc Leavey M.D.	7600 Osle		ite	315	- 21204				0		
- 1	AUG 0 1 1995	A DENSTRANS	SIGNATURE .									
	MULL OF LALL OF											



	Đ	1	210-10-7100
	3 should	_	9e. FACILITY NAME (If not institution, giv
	es es	6	RIVERVIEW NU
	÷.	2	RESIDENCE OF DECEDENT 10a. STATE 10b. COU
	burial-transit permit. Pages 1, 2,	E	
	Ä.	0	MD BA
	per	₩.	100. STREET AND NUMBER
	ansit	Ü	SHAKEBELL
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5-0	as the	B	
21	use a	世	15. DECEDENT'S EI (Specify only highest gra
2 5	Ď.	Ë	Elementary/Secondary (0-12)
BALTIMORE, MARYLAND 21215-0020 for death. Page 6 may be retained by the breathst or attending physics	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. I, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	TO BE COMPLETED BY FUNERAL DIRECTOR	7
Z F	deta	8	17. FATHER'S NAME (First, Middle, Last)
<u>Z</u>	a be	m	HEARY WAR
AF	shoul		190. INFORMANT'S NAME (Type/Print)
S 3	ending physician and completely filled in by the funeral director, page 5 should be detach! Hygiene prior to burial, cremation, or removal. or other traumatic event, the medical examiner must be notified at once.	F	ELIZABIETH WI
ж Ж	pag :		200. METHOD OF DISPOSITION
<u></u>	ector.		1 Buriel 2 Cremetion 3 Re 4 Donetion 5 Other (Specify)
2 &	al dir		21. SIGNATURE OF PINERAL SERVICE
A die	funer		Homen (
00	the oval.		Thorat Y
52	ertificate has been signed by the attending physician and completely filled in by the the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal or titem 23 shows any injury, or other traumatic event, the medical or		23. PART i. Enter the diseases, p shock, or heart fellun
5	n, or		IMMEDIATE CAUSE (Final
S. C.	natio		disease or condition resulting in death)
9	crer		
28.0	d cor urial.	z	Section Control of the Control of th
Ф §	to b	일	Sequentielly list conditions, if any, leading to immediate
	sicia prior trat	8	cause. Enter UNDERLYING
Tifica	a physene	Ĕ	CAUSE (Disease or Injury that initiated events
0 P	Hygi	듄	resulting in death) LAST
S, F	ental	PHYSICIAN: MEDICAL CERTIFICATION	
VITAL RECORDS, P.O. BOX 68760. AN: The law requires that the death certificate be executed with	icate has been signed by the atte State Dept. of Health and Mental Item 23 shows any Injury,	AL	PART II. Other aignificent condition
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	Sign Heal	ij.	di
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A L	has Dep	A	25. WAS CASE REFERRED TO MEDICAL
	State	2	EXAMINER?
F V	the S	¥	27. MANNER OF DEATH
ō ‱	R: After this of death with is marked		1) Natural 5 Pending
Z S	eath ma	B	2 Accident Investigation
	DR. A	0	3 Suicide 8 Could not b 4 Homicide determined
OIVISION OI OR ATTENDING PHYS	RECTOR Ins afte		
5 5	hou iter	7	29e. CERTIFIER (Check only 1 CERTIFYING PHY
DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 8 may be related by the honoring or attended to th	TO THE FUNERAL DIRECTOR: After this of filed within 72 hours after death with IMPORTANT: It item 28 is marked	BE COMPLETED	one) 2 MEDICAL EXAMI
HOS	FUN	Ö	296, SIGNATURE AND DITCE OF CERTIF
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2	₽ 8 X	2	30. NAME AND ADDRESS OF PERSON V
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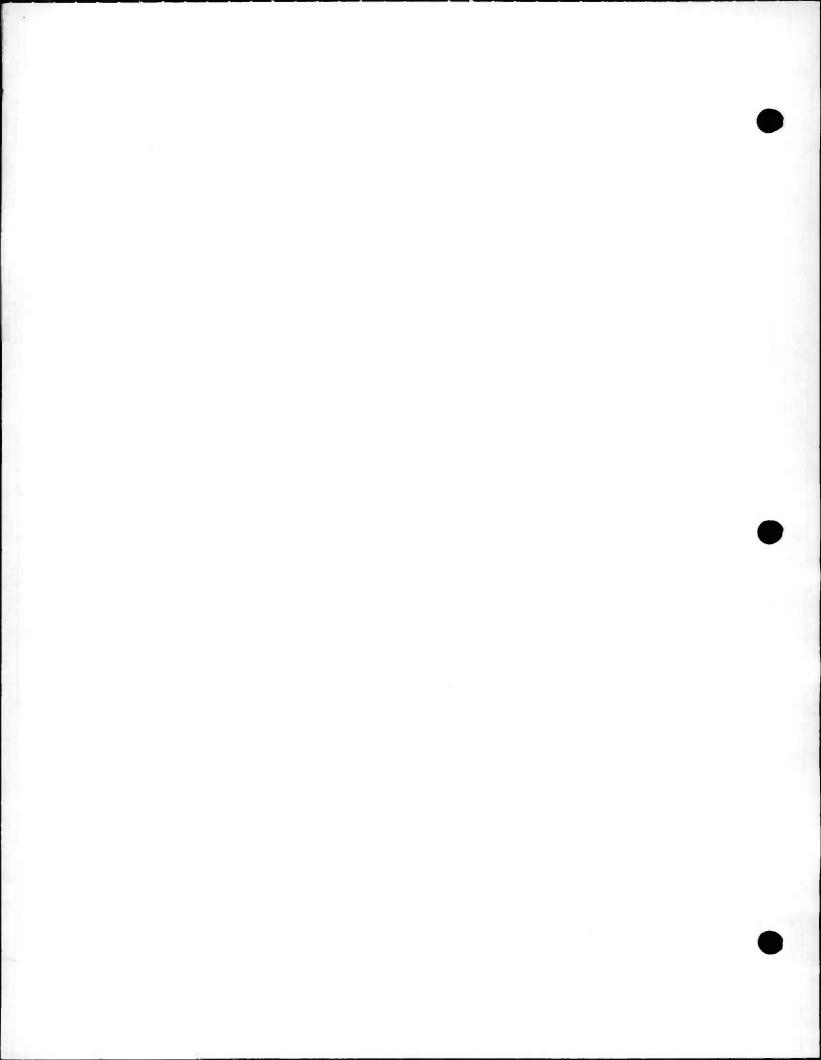
STATE OF MARYLAND / DEPARTMENT OF	HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF	FDEATH	REG. NO.

	1 - STATE OF MARYLAND / I CE	DEPARTMENT OF	HEALTH AND	MENTAL HYGIENE REG. NO.	E				
	1. DECEOENT'S NAME (First, Middle, Last) LEWIS WARFIELD			2. DATE OF OEATH MONTHLY 254	, 1995 YEAR	3. TIME OF DEATH 5:45 am			
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. lest to the second of	VRS. IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	06 8. BIRT	THPLACE (State or Foreign			
OB	90. FACILITY NAME (If not institution, give street and number) RIVERVIEW NURSING CENTRE, INC.		SSEX		BALTI				
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MD. BALTI HOLE	10c. CITY, TOWN OR LOC				10d. INSIDE CITY LIMITS?			
FUNERAL D	100. STREET AND NUMBER - 3 HALF REII AT T2		IOT. ZIP CODE		10g. CITIZEN OF	1 VES 2 NO			
BY FUNE	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES	or No— 14. RAI Bla Spe	CE — American Indian, ick, White, atc.						
COMPLETED									
BE COM	17. FATHERY HAME (First, Middly, Just) HEARY WARFIELD	-2/10032/	-	ME (First, Middle, Maiden S					
TO 1	190. INFORMANT'S NAME (TYPE/PINT) ELIZABIETH WARFIELD 190.	MAILING ADDRESS (Street	end Number or Rural	Route Number, City or Town	State, Zip Code)	21236			
	1 Buriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify)	D DATE OF DISPOSITION IN	DHY 1	-26-45 BA	CATION — City or CO	Town, Stata			
	21. SIGNATURE OF RIMERAL SERVICE LICENSEE	SKA	AND ADDRESS OF FA	2829 H	MD-	ST' 21224			
CERTIFICATION	Sequentielly list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE. (Disease or Injury that initiated events OUE TO (OR AS A CONSEQU	CALDIA JENCE OF): JENCE OF):	~		atory arrest,	Approximate interval Between Onset and Death 5 M (A)			
- CER	PART II. Other significent conditions contributing to deeth but not res	estition in the conduct of		5 I					
MEDICAL			ng cause given in	Pert i. 24a. WAS AN A PERFORM 1 YES 2	MEO?	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH 25. WAS CASE REFERRED TO MEDICAL 26. PLACE	H YES NO	-	N D					
YSIC	EXAMINER? 1 YES 2 90 HOSPITAL: 1 Inpetient 2 ER/Outpetient 3		me 5 - Residence	8 Other (Specify)					
ВУ РН	1) Natural 5 Pending (Month, Day, Year)	M 1	JURY AT ORK? YES 2 NO	28d. DEŞCRIBE HOW IN.	JURY OCCUREO	Take.			
ETED	3 Suicide 8 Could not be 4 Homicide datermined 28e. PLACE OF INJURY — At home building, atc. (Specify)	s, farm, street, factory, offi	Ice	281, LOCATION (Street en City or Town, State)	d Number or Rural	Route Number,			
COMPLETED	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death one) MEDICAL EXAMINER: On the best of examination and/or inv					(e) end manner ee stated.			
# F	296, SIGHATURE AND DITCE OF CERTIFIER		29c. LICENSE NUM		29d. DATE SIGNE	D (Month, Day, Year)			
임	8100 Harford Road, Baltimore,	27) (Type, Print) Maryland 2							
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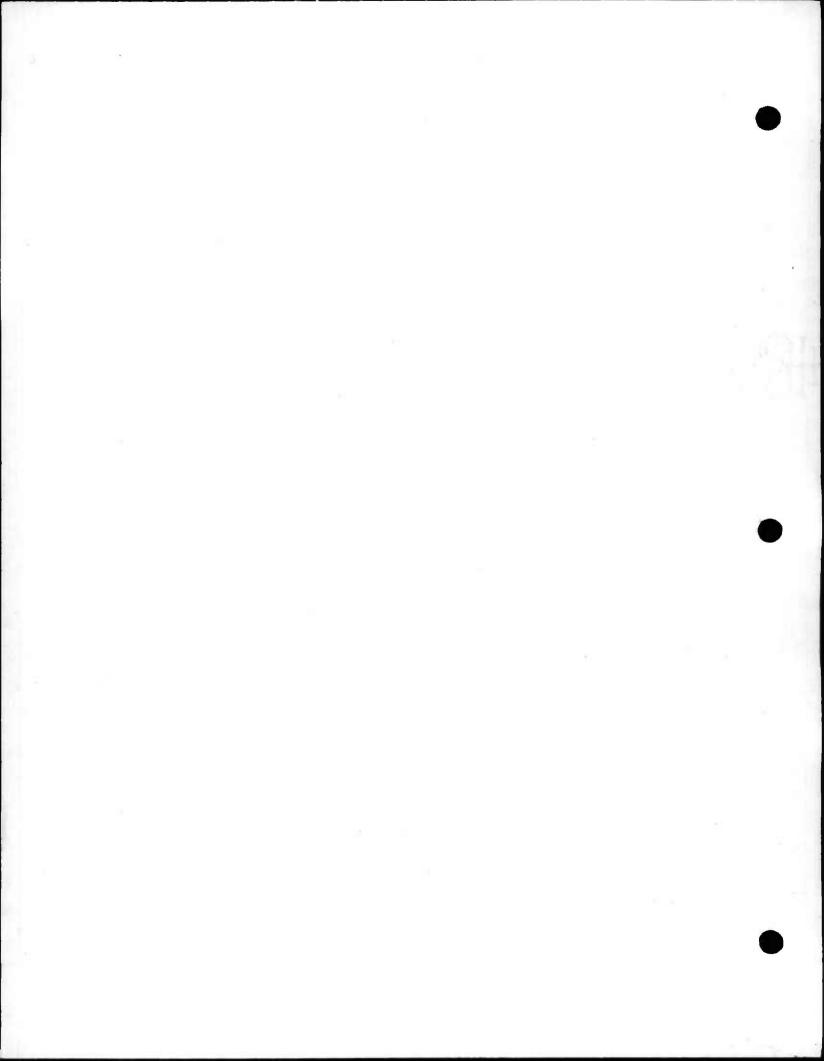
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending plays	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burity	90	

	1 - STATE REGISTRAR	STATE OF MARY			OF HEALTH AN		REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)	Witner					TE OF DEATH		3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 164-30-1506	5. SEX 8. AGE	(In yrs. last birthda	MONTHS	YEAR IF UNDER 24 H DAYS HOURS MI	н. (М	TE OF BIRTH onth, Day, Year)		BIRTHPLACE (State or Foreign Country) Pennsylvania	
TOR	90. FACILITY NAME (If not institution, give a Bay View Host RESIDENCE OF DECEDENT				own on Location of			9c. COUNTY	y of death N?A	
DIRECTOR	10e. STATE 10b. COUNT Md. N/A	COUNTY 10c. CITY, TOWN OR LOCATION							10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
FUNERAL	100. STREET AND NUMBER 3602 East Lon	bard Street			101. ZIP CODE 21224		10g. CITIZE	N OF WHAT COUNTRY?		
COMPLETED BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 X YES IF YES, OIVE WAR OR I 1955-1959	2 NO	11 1	S DECENDENT OF HI yes, specify Cuben, M YES 2 NO S	SPANIC ORI exican, Puer pecify:	GIN? (Specify Yea to Rican, etc.)		Black, White, etc. Specify: White	
	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION	16a. DECEDENT	of work done du use retired.)	UPATION ring most of working		Taxic	INESS/INDUS		
l w l	17. FATHER'S NAME (First, Middle, Last) Lester Wi	tmer			18. MOTHER'S	_	nknown	Surname)		
TO B	190. INFORMANT'S NAME (Type/Print) Linda Roberts		18 W	indjam	Street end Number or R		x,Md. 2	1221		
	20e. METHOD OF DISPOSITION 1 © Burlei 2 Cremation 3 Rem 4 Donation 8 Other (Specify) 21. SIONATURE OF FUNERAL SERVICE LIK	oval from State Ca	b. PLACE AND DAT metary, crematory of acred He	eart of	E Jesus Co	em 8-	2-95 D	undalk	y or Town, State	
	Charles S. Zeiler & Son Inc. 6224 Eastern Avenue Balto., Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arreat, interval Batweel interval Batweel disease or condition. Approximate interval Batweel Onset end Deat									
CERTIFICATION	disease or condition resulting in desth) a. Mc dastrib C carcing of unknown primary Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in desth) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									
MEDICAL	PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i.								24b. WERE AUTOPSY FINDS AVAILABLE PRIOR TO COMPLETION DF CAUS DF DEATH?	
SICIAN:	DID TOBACCO USE CONTI	HOSPITAL:	28. PLACE OF DE	OTHER:	y one)					
ву Рну	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. T	IME OF 20	g Home 8 Resider Bc, INJURY AT WORK? 1 YES 2 NO	28d. C	her (Specify) ESCRIBE HOW IN	JURY OCCUR	ED	
ETED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, etc. (Spe	icity)			- 0	ty or Town, Stete)		Rural Route Number,	
COMPL	2 MEDICAL EXAMINE								euse(s) end menner es stated	
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER John Baldon 30. NAME AND ADDRESS OF PERSON WHI	me M.C	-	ne Printi	3 6 0			29d. DATE SI	GNED (Month, Day, Year)	
	Todd Baldan 31. DATE FILED (Month, Day, Year)		wille	im St	. Balt	man	, mo	21	230	



BALTIMORE, MARKLAND 2X215-0020	fter death. Page 5 may be mainted to the contracting physician. The funeral director page 5 should be as the burial-transit permit. Pages 1, 2, 3 should oval.	al examiner must be notified a page.	TO BEDOMPLETED BY FUNERAL DIRECTOR	1. DE 1. DE
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page is may be real TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page is be filed within 72 hours after death with the State Dept. of Health and Mental Hygiehe prior to burial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	PARTI
	TO THE TO THE De filed	IMPOR	TO BE	30. NA

1 - STATE REGISTRAR	STATE OF MA					DEATH AND	MENTA	L HYGIEN			
1. DECEDENT'S NAME (First, Middle, Last)	9172 Ruth	Elaini	s White	ehair			2. DATI		AY O	YEAR 95	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 217 40 8293	5. SEX 8.	AGE (In yrs. Is	yrs.	IF UNDE	R 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE	of BIRTH	-	8. BIRTI- Counti	IPLACE (State or Foreign y) yland
9a. FACILITY NAME (If not Institution, give s Bay View Hospita	atreet and number)					imore		20 00	9c. COU	TY OF O	
RESIDENCE OF DECEDENT					Dail	пюте			117		
10a. STATE 10b. COUNTY	10c. CIT		or locat						10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
104. STREET AND NUMBER 3711 Hudson Sti		-		ZIP CODE 21224			10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1									y:		
15. DECEDENT'S EDU- (Specify only highest grade Elementary/Secondary (0-12) Unknown		(I	ECEDENT'S Give kind of w le. Do NOT us	vork done e retired.)	during mos	N st of working	16	b. KIND OF BU		USTRY	
17. FATHER'S NAME (First, Middle, Last)			- GABCW	OLIV							
John Kafer						18. MOTHER'S NA		middie, Maiden Enagle	Sumame)		
19a. INFORMANT'S NAME (Type/Print)		11	Db. MAILING	ADDRES	S (Street =	nd Number or Rural			n State 7in	Code	
John G. Casey			7473	Rabo	n Av	enue Dur	ndal	Md.	2122	2	
20e. METHOD OF DISPOSITION 1 Spurier 2 Cremation 3 Rame 4 Donation 5 Other (Specify)	oval from Stata	20b. PLACE	AND DATE O	of DISPO	SITION (Ne		DAT	E 20c. LO	cation - C	Cify or To	
21. SIGNATURE OF FUNERAL SERVICE LIC	J. Bell		<u> Lawiii</u>	22.	Char	ADDRESS OF FA Les S. Z S. Conkl	eile	er & Sc	on Inc	c.	<u> </u>
	a. SEPS / DUE TO (OF	S A CONSE	OUENCE OF):			h ss cer	diec or respi	iratory arre	est,	Approximate Interval Between Onset and Death
If sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR	AS A CONSE	BOW QUENCE OF): <u>E</u> L):							two week
PART II. Other significant condition	s contributing to de	ath but not	reculting in	n the u	ndarlyling	cause given in	Part I.	24a. WAS AN PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
DID TOBACCO USE CONTR	RIBUTE TO CAUS	E OF DE	ATH YE	s 🗆	NO 🛭	UNCERTAIN					1 TYES 2 TO NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO	HOSPITAL:		DOA	OTHE	R:	5 Residence	6 🗆 Othe	er (Specify)			
27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	26s. DATE OF INJ (Month, Day,)		28b. TIME INJU		28c. INJU WOF 1 Y		28d. DE:	CRIBE HOW II	NJURY OCC	URED	
3 Suicide 6 Coutd not be detarmined	28a. PLACE OF IN building, etc.	JURY — At he (Specify)	oma, farm, si	treel, fac	tory, office		26f. LOC City	ATION (Street a or Town, State)	and Number	or Rural A	oute Number,
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER											and manner as stated
296. SIGNATURE AND TITLE OF CERTIFIER						29c, LICENSE NUN		1			
30. NAME AND ADDRESS OF PERSON WHO	mo -	JUN			ENT	MG11					(Month, Day, Year) 30, 1995
MONICA SHA	HMD	JOHN			KIN	S HOS	PIT	AL			



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0 30 **EXAMINER?** 1 TES 2 NO

1 Natural

2 Accident

3 Suicide

4 Homicide

27. MANNER OF DEATH

Pages 1, 2, 3 should

permit.

BOX 68760 Od DIVISION OF VITAL RECORDS.

	DALTINOTE, TARIFORDA, TOTAL OF THE CALL OF	DALTINONE, MANTERIND 21213
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an in	ours after death. Page 6 may be retained by the hospital or attendi
V	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as t	in by the funeral director, page 5 should be detached for use as t
1	 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or 	or removal.

95 23130 Item18 8-1-95 FilmG726 W.H.Per F/H STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Legt) Watson 2. DATE OF DEATH 3. TIME OF OFATH Linda JULY 12:00 Am 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. ileginici 3 9a. FACILITY NAME (If not institution 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Ba Marylano 5 1 VES 2 | NO Mes/E 100. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 22 2 2121 2 101 E 07 SA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No it yea, specify Cupan, Mexicen, Puerto Rican, atc.)

1 YES 2 SCHO Specify: 14. RACE — American Indian, Black, White, atc. Never Merried 2 Merried specify Black BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ive kind of work done Oo NOT use retired.) entary/Secondary (0-12) College (1-4 or 5 +) ook stru ND 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maide .) liams Th oma BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Stre 9 ONES 80e. METHOD OF DISPOSITION
1) Burlat 2 Cramation 3 Ramoval from Stata
4 Donatton 5 Charles A LOCATION 20b. PLACE AND DATE OF DISPOSITION (No 3a Donatton 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY 13 Jeen TOPLES MANN 23. PART I. Enter the dieeeses, or complications that caused the death. Do not enter the mode of dying, euch as cardiec or reepiratory arrest, Approximate shock, or heer failure. Liet only one ceuse on each line. Intervel Between IMMEDIATE CAUSE (Finel) Onset end Death disease or condition Urosepsis 6days resulting in death) DUE TO (OR AS A CONSEQUENCE OF): ongestive Yeous CERTIFICATION Sequentielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significent conditione contributing to deeth but not resulting in the underlying cause given in Pert I. MEDICAL

Hypertension

24a. WAS AN AUTOPSY PERFORMED? TYES 2 TH NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN IT 25. WAS CASE REFERRED TO M

W

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EDICAL	28. PLAC	E OF DEA	TH (Check	only one)		
	SPITAL: Inpatient 2 - ER/Outpatient 3	□ DOA	OTHE 4 Nu	R: rsing Home	5 - Residence	6 Other (S
	28a. DATE OF INJURY	28b. TIN	E OF	28c. INJUI		28d. DEŞCR

Specify) IBE HOW INJURY OCCURED

М 1 YES 2 NO 28e. PLACE OF INJURY - At home, term, street, tectory, office

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a, CERTIFIER 1 D CERTIFYING PHYSICIAN: beat of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner ea stated. 2 MEDICAL EXAMINER: On ation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29d. DATE SIGNED (Month, Day, Year) 27 1995 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER W ale

	0 4/~	0,0	-			_		
. NAME AND	ADDRESS	OF PERSON	WHO	COMPLETED	CAUSE OF	DEATH (ITE	4 27) (Type,	Print)
/1				1 1	and the same of th	-4 (-

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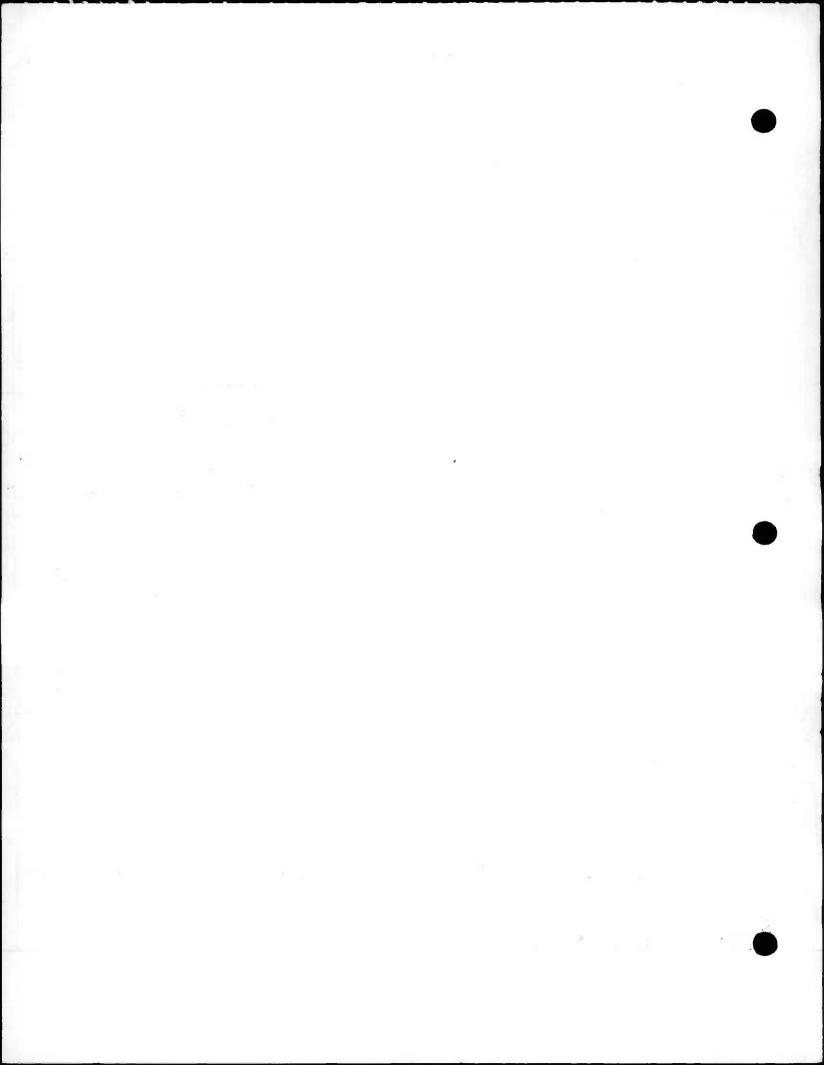
21216

2600 Libert George E. Wicks W M.D. 31. DATE FILED (Month, Day, Year)

Investigation

6 Could not be

32. REGISTRAR'S SIGNATURE



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	DOMINS A
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.O. B.	certificate
ري ص	death
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3	hat
RECC	requires !
	W.
I	The
OF VI	PHYSICIAN
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within
5	08
	OSPITAL

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN YEAR Thomas Wayne Williams 995 5:40 V.TIIT. 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)
NOV. 19,1952 5. SEX 8. AGE (In vrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign Country) 218-64-4128 1 M 2 F 42 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Johns Hopkins Bayview Baltimore City City RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland City Baltimore City MX YES 2 NO permit. 10e. STREET AND NUMBER 10f. ZIP CODE FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 3135 O'Donnell Street for use as the burial-transit 21224 U.S.A. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yas or No—
If yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY 1 YES 2 NO Specify Specify: 3 Widowed 4 Divorced White 18a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Steel Worker funeral director, page 5 should be detached Bethlehem Steel 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Sumame) Claude Williams notified at Helen Nolan BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Cynthia Williams 3135 O'Donnell Street Baltimore, MD 21224 pe 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE examiner must 2 Cremation 3 Re 4 ☐ Donation 5 ☐ Other (Specify) G<u>len</u> Haven Cemetery 7/31/95 Glen Burnie, MD 21. SIGNATURE OF FUNERAL SAMPICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lilly & Zeiler, Inc. Funeral Home 1901 Eastern Ave. Balto., MD 21231 the the medical in by t 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or haart failure. List only one cause on each line Intarvai Batween ō completely filled **IMMEDIATE CAUSE (Final** Onset and Daath cremation, disease or condition resulting in death) *Arteriosclerotic Cardiovascular Disease traumatic event. DUE TO (OR AS A CONSEQUENCE OF) prior to burial, c CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate the attending physician Mental Hygiene prior to cause. Entar UNDERLYING CAUSE (Diseasa or injury 23 shows any injury, or other DUE TO (OR AS A CONSEQUENCE OF): that initiated avanta reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL been signed by th PERFORMED? 1 TES 2 NO OF DEATH? 1 YES 2 □ NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN A PHYSICIAN: has by Dept. 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) certificate I Item HOSPITAL OTHER: 1 Q YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Rasidenca 8 Other (Specify) marked, or 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED this (1 Natural 1 YES 2 NO ВҰ After 1 2 Accidant 28s. PLACE OF INJURY — At home, larm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 99 ETED 8 Could not be DIRECTOR: after 4 Homicide determined Item 28 hours COMP 1 CERTIFYING PNYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE Be filed within 72 hr w. only 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 96. SUNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE JULY 31,1995 o.c.m.e. Ø NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201 32. REGISTRAD'S SIGNATURE

4 6

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be refaired by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Opp. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYEAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

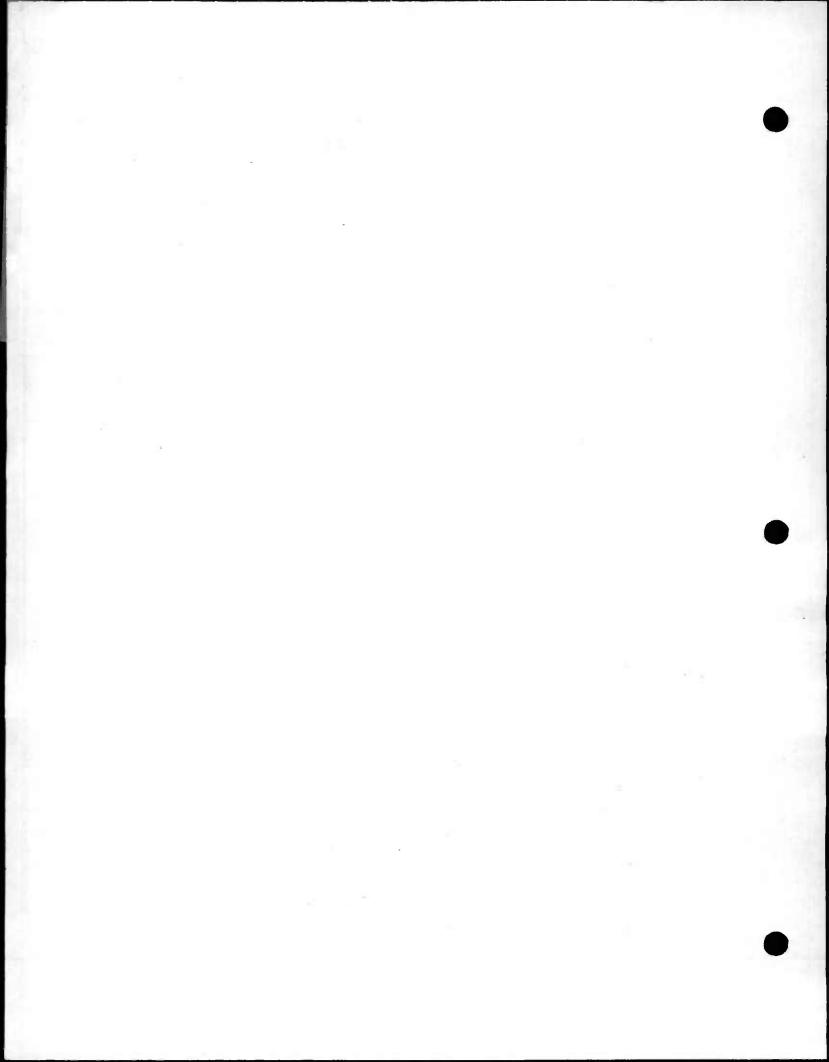
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

1. DECEDENT'S NAME (First	, Middle, Last)			02.11111			D LA		2. DATE OF	DEATH			3. TIME OF DEATH
RONNIE					M	ILS	SON		JULY	2	Y	YEAR 95	5:03 P.M
4. SOCIAL SECURITY NUM	DER	5. SEX	6. AGE (In y	rs. lest birthday)	IF UNDER		IF UNDER	24 HRS	7. DATE OF		1		PLACE (State or Foreign
215 70 6245		### M 2 □ F	35	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, E 8/9/5	Day, Year)		Country	D.
9a. FACILITY NAME (If not in					9b. CITY	. TOWN	OR LOCATIO	ON OF DE		9	ac cour	TY OF D	
HOPKINS BA			J. CE	NTER	RΔ	T.T.T	MORE	СТ	TV		Su. 5001	0. 0.	DAIN .
RESIDENCE OF DEC	CEDENT				1021	<u> </u>	HORL	, С1					
DALTO CITY DALTIMODE											10d. INSIDE CITY LIMITS?		
MD.	RALI	O. CITY			RALI	TMO	KE						1 # YES 2 NO
10e. STREET AND NUMBER	LL LOW	BARD ST.				-10	H. ZIP CODE						HAT COUNTRY?
	W. LUI						2120					SA	
11. MARITAL STATUS 1 // Never Married 2 //	Married	12. WAS DECEDEN FORCES? 1	YES 2	2 III NO	13.	WAS DE	CENDENT O pecify Cubar	F HISPAN	IIC ORIGIN? (Specify Yes an, etc.)	or No-	14. RACE Black	— American Indian, , White, elc.
3 Widowed 4 Divo		IF YES, GIVE V	WAR OR DATE	s #		1 🗌 YES	s #∏ NO	Specify	/ :		1	FR.	ÄMERICAN
15. DEC	EDENT'S EDU	CATION	16	a. DECEDENT'S	USUAL O	CCUPATI	ION		18h Ki	IND OF BUS			APIERICAN
(Specify onl	y highest grade	completed) College (1-4 or 5		(Give kind of life. Do NOT us	work done i se retired.)	during m	ost of working	9	100. 10	NO 01 B03	MESSIND	USINI	
12	_	0	"	unempl	oyed					none	5		
17. FATHER'S NAME (First, M	iddle, Last)				-		18. MOTH	ER'S NA	ME (First, Mide	die, Maiden S	Sumame)		
JOHN	WILSON	l						CHEL		ANDFO	,		
19e. INFORMANT'S NAME (end Number	or Rural F	Route Number,	City or Town	, State, Zip	Code)	
RACHEL B.	<u>MURDOC</u>	K							ALTO.				
20a. METHOD OF DISPOSITE 1. ☐ Burlal 2 ☐ Cremetic	n 3 Rem	mel from State		ACE AND DATE			lame of		DATE	20c. LOC	CATION —	City or Tov	vn, State
4 ⁷ □ Donation 5 □ Other	(Specify)		- WES	TERN ST	AR	7/2	8/95		4	CATO	NSVI	LLE,	MD.
21. SIONATURE OF FUNERA	L SERVICE LIC	ENSEE	,		22.	NAME A	ND ADDRES	S OF FA	RS FUN	IEDAL	HOME	D A	
1/1018	N	001	10										
23. PART I. Enter the di	seasea, or o	epmplicetions that	t caused th	e deeth Dn r	ont enter	3UU	EUTA	W PI	BAL	.10. 1	1U. Z	121/	
anock, or n	eert tellure.	List only Dne ceu	se on each	line.			ode of dyn	ig, euc	i de Celulei	c or respii	atory arre	oet,	Approximate interval Between
iMMEDIATE CAUSE (Fir disease or condition	nei	MYOCARDI	AL CIDO	OCTE AME	CATT	V Mc	TAMORD	HUCLO	OF THE	E LIVE	D		Onset and Death
resulting in desth)		P		INSEQUENCE D		1 01	TAHURF	HOSTS	o or in	r rive	η.		
	_	CHRONIC											İ
Sequentielly list conditi		0.		INSEQUENCE OF	F):								
cause. Enter UNDERLYI	NG												
CAUSE (Disease or inju thet initiated events	ν) (DUE TO	(OR AS A CO	NSEQUENCE OF	F):								
resulting in deeth) LAS	T	1.											
PART II. Other eignifice	nt condition	e contribution to	double built									_	
TAIT II. Other eighnice	CONGREDI	s contributing to	death but i	not resulting	in the un	deriyin	ig cause g	iven in	Part I. 24	PERFORI		1	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
									— 汋	YES 2	□ NO		COMPLETION OF CAUSE DF DEATH?
DID 2004 4400									`				res 2 🗆 NO
DID TOBACCO U		RIBUTE TO CA						ERTAIN	1 🗆 📗				
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		PLACE OF DEAT	OTHER	R:							
1 XYES 2 NO		1X Inpatient 2			4 🗆 Nun	ing Hor		idence	6 Other (S				
1000	Pending	28e. DATE OF (Month, D		28b. TIM INJ	E OF URY	WC	JURY AT ORK?		28d. DESCR	IBE HOW IN	JURY OCC	URED	
2 Accident	investigation	280 81 407 0	EMILIN	At home desired	**		YES 2	NO					
	Could not be	building,	etc. (Specify)	At home, farm, s	streel, facti	ory, offic	00		28f. LOCATION OF T	ON (Street ar fown, State)	nd Number	or Runal Ro	oute Number,
20. 05071775		1											
(Check ogly		CIAN: To the beat of											
1			kamination an	d/or investigatio	n, in my o	pinion, d	death occure	d at the	lime, date and	d piece, end	due to the	ceuse(s)	end menner as stated.
296. SIGNATURE AND TITLE	OF CERTIFIER		290				29c. LICE	NSE NUM	IBER		29d. DATE	SIGNED	(Month, Day, Year)
///	_	$\nearrow \infty$					0	.C.	M.E.		J	ULY	22,1995
30 NAME AND EDDIESS OF	PERSON WHI	COMPLETED CAU			,	Str				ore,	Mar		nd 21201
DATE FILED (Month, Day,	-	32. REGISTRA	R'S SIGNATU	RE									
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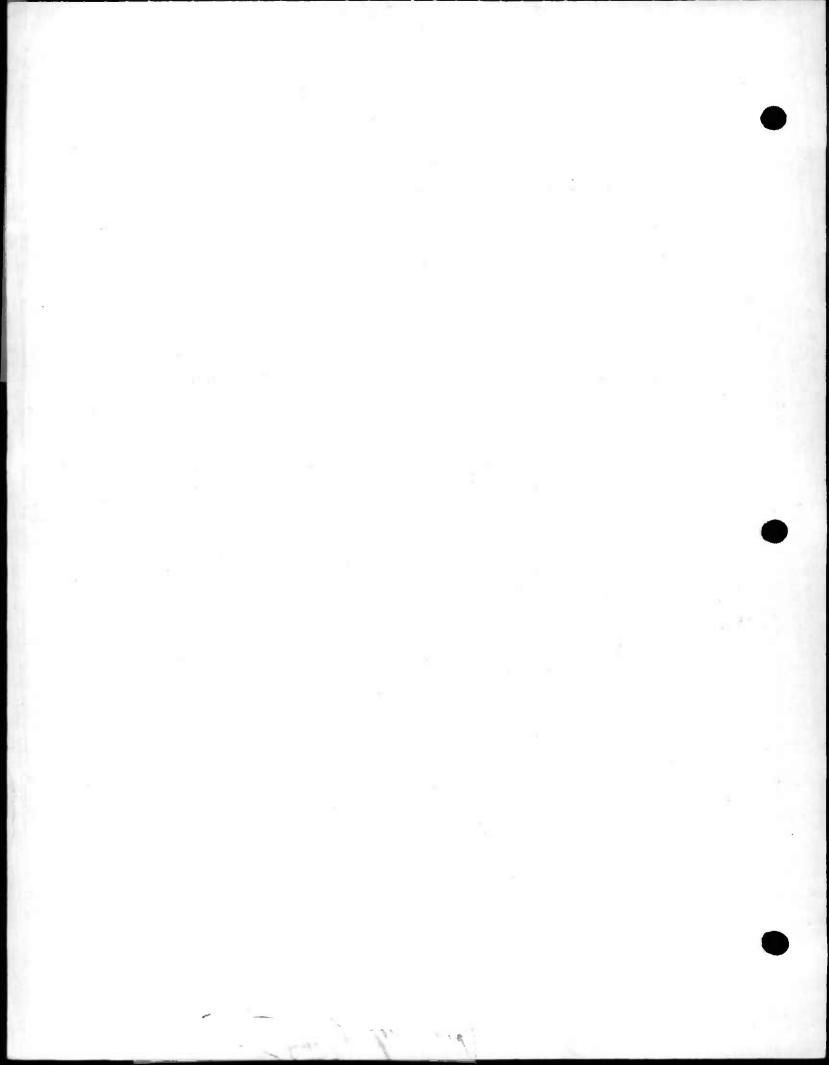
		1 - FOR STATE REGISTRAR	STATE OF MARYL				EALTH AND DEATH	MENT	AL HYGIEN			
		DECEDENT'S NAME (First, Middle, Last) OSCAR			ITEMA			MOI	TE OF DEATN	MY	WE AD	TIME OF DEATH
멀		448-12-3294	1 🗶 M 2 🗆 F	n yrs. lest birthda 71 YRS	MONTHS	DAYS	IF UNDER 24 HRS. HOURS MIN.	Feb.	TE OF BIRTIN onth, Day, Year)		Okla	ACE (State or Foreign
, 2, 3 should	TOR	99. FACILITY NAME (If not institution, give street Saint Joseph Medical RESIDENCE OF DECEDENT					on, Mary	DEATN		9c. COUNT	y of DEAT	
DCC physician. burial-transit permit. Pages 1,	DIRECTOR	Maryland N/A			altimo		ION				i i	d. INSIDE CITY LIMITS? X YES 2 \(\square\) NO
in. ansit perm	FUNERAL	100. STREET AND NUMBER 707 Hollen Road					21212			Unite	N OF WHA	T COUNTRY?
attending physician se as the burial-trai	BY	1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DA WORLD WA	2 NO	11	yes, spe	ENDENT OF NISPA celty Cuben, Mexic 2 NO Spec	can, Puerl	SIN? (Specify Ye o Rican, etc.)	s or No — 1	4. RACE — Black, W Specify:	American Indian, thite, etc.
spital or red for u	COMPLETED	15. DECEDENT'S EDUCATION of the property of the property (0-12) Blementary/Secondary (0-12)	TION mpleted) College (1-4 or 5+)	16a. DECEDEN' (Give kind iffe. Do NO: Forema	of work done di Luse retired.)	CUPATIO	IN at of working	1	Bethle			
क्र वर्	اسا	17. FATHER'S NAME (First, Middle, Leat) Samuel Bell Whitem	nan				18. MOTHER'S N. Marieti		, Middle, Meiden		iemer	
y be retained hage 5 should be notified	TO B	190. INFORMANT'S NAME (Type/Print) Helen S. Whiteman					nd Number or Rural oad Balt				,	2
Page 6 may be all director, page		20e. METNOD OF DISPOSITION 1 X Burial 2 Cremetion 3 Remova 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN	of from State Come	PLACE AND DA	of Fai	th (Cemetery	7 7/		erlea,		
death. funer:		> Jeven T. Ett	te		M: 6:	itch 500	o address of F nell-Wie York Ro	defe	altimo	re. M	212	12
ely fille ration,		23. PART i. Enter the diseases, or corshock, or heert failure. Lis iMMEDIATE CAUSE (Finel disease or condition resulting in dasth)	ACUTE MYO	CARDIA	L INFAF			ch aa ce	rdiec or reap	iratory srrea	nt,	Approximata Interval Between Onset and Death 6 HOURS
executed and con o burial,	CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A			· · · · · ·						
th certifical ending phy il Hygiene p or other	CERTIFIC	CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE	OF):							
that the ded by the hand Men	MEDICAL (PART II. Other significent conditions of METASTATIC MERK			g in the und	derlying	ceuse given in	Part I.	24a. WAS AN PERFOR 1 PES 2	RMED?	AW CO OF	RE AUTOPSY FINDINGS MILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
23 tent	SICIAN: 1	DID TOBACCO USE CONTRIE	2	DEATH		_	UNCERTAI	N 🗆				
SICIAN: The certificate the State	PHYSIC		OSPITAL: Inputient 2 ER/Output 28e. DATE OF INJURY				5 - Residence	1				
PHY stit	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		NJURY M	1 🗌 Y	ES 2 NO		ESCRIBE NOW I			
DR ATTENDING DIRECTOR: After hours after death item 28 is ma	ETED	3 Suicide 6 Could not be determined	25e. PLACE OF INJURY - building, etc. (Specif					Cit	CATION (Street a y or Town, State)			Number,
로 크 ~ =	COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	On the basis of essentiation	odge, death occu	irred at the tim	ne, date i	and place, end due ath occured at the	e to lhe c	euse(e) end mer te end place, en	nner ee stated d due to the o	suse(s) en	d menner es stated.
TO THE HOSPIT TO THE FUNERA be filed within 7 IMPORTANT:	TO BE	296. SIGNATURE AND TITLE OF CENTIFIER	28-4	well	2		29c. LICENSE NU D 3681			PO DATE S	C C	6 /95
1			M.D., 7620 Y	ORK RO	AZ TO	wsc	DN,MARYL	LAND	21204			i é
0		AUG 0 1 1995	32. RESISTRAR'S SIGNA	TURE	4							



FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN 730 Richard ohn Jul 1995 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year) 1 M 2 | F DAYS HOURS 9-3-06 Maryland 88 217-07-4234 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Agnes Hospital Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 X YES 2 | NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit U.S.A. 1015 Beechfield Avenue 21229 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or Nohours after death. Page 6 may be retained by the hospital or attending physician 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE — American Indian, Black, White, atc. Specify: White BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TYES 2 NO Specify: BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 7th Salesman Buildina 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) Ħ John R. Wade BE Dorothy C. Coonan notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ann Bauer Beechfield Avenue-Baltimore, Maryland 2122 Pe 20a. METHOD OF DISPOSITION

1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE RONald Wade, Dir. medicai examiner 22. NAME AND ADDRESS OF FACILITY State Anatomy Board-655 W. Baltimore Street Rm. B026-Baltimore, Maryland 21201-1559 and completely filled in by the burial, cremation, or removal. 23. PARK i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Final Onset and Death #e disease or condition Bronchopneumonia other traumatic event, resulting in death) 3-5 days DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to If any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to the death certificate be CAUSE (Diseese or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 50 PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL Health and any Status post right Hemicolectomy 1 XYES 2 NO DF DEATN? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN HOSPITAL OR ATTENOING PHYSICIAN: The law if FUNERAL DIRECTOR: After this certificate has be within 72 hours after death with the control of t PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 🔀 Inpatient 2 □ ER/Outpatient 3 □ DOA 6 - Other (Specify) 28s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATN marked, 28h TIME OF 28c. INJURY AT WORK? 28d. DEŞCRIBE NOW INJURY OCCURED 1 🙀 Natural
2 🔲 Accident 1 YES 2 NO B 26s. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 50 COMPLETED 6 Could not be 28 4 Nomicide item 29a. CERTIFIER (Check only (Ch = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT; II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE m.D. D08949 July 26, 1995 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bert F. Morton, M.D., St. Agnes Hospital, 900 Caton Ave., Balto., Md. 21229 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

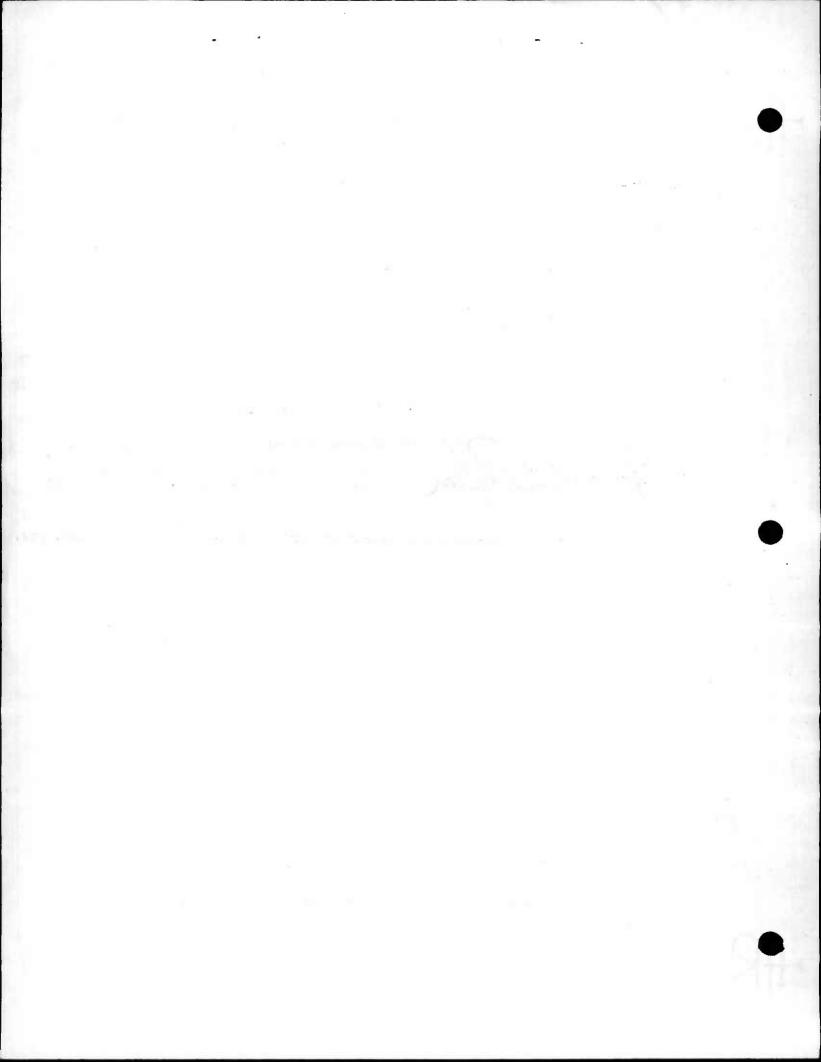
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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Residence of processors Secretary Se	Shou	~	9a. FACILITY NAME (If not in	nstitution, give s	treet and number)				9b. CITY	TOWN	OR LOCATI	ON OF D	EATH		9c. COUN	Y OF DEA	тн
10		l ö			al Hospit	al			Camb	rid	ge				Dorch	ieste	er
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Attring in death) a. Attring Cardiovascular disease Sev. yrs Oue to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Oue to (or as a consequence of): Due to (or as a consequence of): Oue to (or	D D D E			/	List only one cau	use on e	och line.										
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injun) that initiated events resulting in death LAST DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN	and and		disease or condition	→	Arto	rioc	clar	otic	car	dion	726611	lar	dice	25P			
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27. MANNER OF DEATH 1	The Last te De Ita	SA		O MEDICAL		1	26. PLACE	OF DEAT	TH (Check o	nily one)							
29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER D15165 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Dey, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mahmood Shariff, M.D. 103 Aurora Street Cambridge, MD 21613 31. DATE FILEO (Month, Dey, Year) 32 REGISTRAR'S SIGNATURE	AN: Tiffical E Sta	SIC			1 Inputient 2	ER/Outp	etlant 3	□ DOA			10 5 □ Ra	aldence	6 Othe	r (Specify)			
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The control of the course of t	ATT RECTORES aff		Homicide	determined													
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31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE		=	30. NAME AND ADDRESS OF	F PERSON WH	COMPLETED CAU	SE OF DEA	ATH (ITEM	27) (Туре,	Print)							, ,	
31. DATE FILEO (Month, Day, 1601) 32. REGISTRAR'S SIGNATURE JUL 1 7 1995 Jaha Dhewleon Randalle					M.D.				Auror	a S	treet	: (Cambr	idge,	MD	216	13
JULI 7 1995 folia di mullian Mardalli					32. REGISTRA	R'S SIGNA	TURE										
			JUL1 7	1995	falsa other	witon-	Marda	14									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 15 hours after death. Page 6 may be retained by the hospital or attending physician.
Ifter th
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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	1 - STATE REGISTRAR	STATE OF MA		DEPAR ERTIF					MENTAL HYGIEN			
	1. OECEDENT'S NAME (First, Middle, Last)		-						2. DATE OF DEATH	AY	YEAR 3.	TIME OF DEATH
		Virgini							July 16			8:45 A. M
	4. SOCIAL SECURITY NUMBER		B. AGE (In yrs. les		IF UNDE	DAYS	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		S. BIRTHPL. Country)	ACE (State or Foreign
	137-32-5282	1 🗆 M 2 💢 F	54	YRS.					May 27, 1	-	New Y	
<u>~</u>	9e. FACILITY NAME (If not institution, give s	and the same of th	7				OR LOCATION		EATH	9c. COL	JNTY OF DEAT	
DIRECTOR	Frederick Memoria	I Hospita	1		1	rede	erick				Frede	rick
Ä	10a. STATE 10b. COUNTY	Y		10c. CIT	Y, TOWN	OR LOCAT	TION				10	M. INSIDE CITY
	Maryland Fr	ederick			Fre	ederi	ick				1	LIMITS?
FUNERAL	10e. STREET AND NUMBER					101	. ZIP CODE	E		10g. CIT	IZEN OF WHA	T COUNTRY?
<u>ii</u>	1204 North Mark	et Street					2170	1		U.	S.A.	
Ē	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEOENT FORCES? 1	EVER IN U.S. AR	IMED NO	13.	WAS DEC	ENDENT O	F HISPAN	IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	a or No-	14. RACE -	American Indian, fhita, etc.
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WA		.0		1 TYES	2 X NO	Specify	r, Puarto Hidan, etc.)		Conntin	
	15. OECEDENT'S EDUC	CATION	140 05	CEOENT'S	HOULE							White
E	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(G life.	ive kind of a	vork done	during mo	on ost of workin	9	16b, KIND OF BU	SINESS/IN	OUSTRY	
COMPLETED	crementary/secondary (0-12)	College (1-4 or 5 +)		Iomem	,				Own 1	Tomo		
O	17. FATHER'S NAME (First, Middle, Last)		1.	MICH	aker		18, MOTH	IER'S NA	ME (First, Middle, Maiden			
ш	George	G. Gat	ti						la Helen	,) Occa	
<u> </u>	19a. INFORMANT'S NAME (Type/Print)	J. 041		b. MAILING	ADORES	S (Street a			Poute Number, City or Tow			
오	Mr. Robert J. Ang	e11	- 1						eet, Fred			21.701
	20a. METHOD OF DISPOSITION 1 Surface 2 Cremation 3 Rame		20b. PLACE	AND DATE (FDISPO	SITION (Na		DUI	OATE 20c. LO			
	4 Donation 5 Other (Specify)	oval from State	Restha	metory or or	her plece,	rial	Gar	dens	July 19 10	995 F	reder	ick MD
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE							July19,19			
	Allow H	Ruly	MOO7	7O3	Ke	eney	7 & B	asfo	ord P.A. F	unera	al Home	9
	23. PART I. Enter the diseases, or o	complications that	aused the de	eth Do s	ot ente)6 Ea	de of dy	hurc	h St., Fre	ederi	ck, M	21701
	anock, or neart renure.	List only one cause	on each line		or unite		ue or oyr	ng, auci	r as cerdiec or resp	iratory er	rest,	Interval Between
	IMMEDIATE CAUSE (Finei disease or condition		,									Onsat and Death
	resulting in death)	DUE TO (O	R AS A CONSEC	OUENCE OF	n:	ed 7	2)				-	44
z	_		- 47 1 -7				C .11 S	_ **				
RTIFICATION	Sequentielly list conditions, if any, leading to immediate		R AS A CONSEC			2.3.25	2 4 4 4					020
S	cause. Enter UNDERLYING CAUSE (Disease or Injury	to	1770	-	,	/	معودة دي	6				45 400
E I	that initiated events	OUE TO (O	R AS A CONSEC	DUENCE OF):							
H	resulting in deeth) LAST	d										
2	PART II. Other significent conditions	s contributing to de	eth but not r	esuiting i	n the u	nderiving	CSUSO O	iven In	Part I. 24s. WAS AN	ALITOROV	Took we	RE AUTOPSY FINDINGS
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0									1 🗆 YES 2	NO	OF	DEATH?
Σ	DID TOBACCO USE CONTR	PIRLITE TO CALL	SE OE DEA	TLI VE	2	NO D	LINIC	ERTAIN			10	YES 2 NO
AN	25. WAS CASE REFERRED TO MEDICAL	CIDOTE TO CAO		E OF DEAT			UNC	EKIAIN	4 🗆 📗			
PHYSICIAN:	EXAMINER?	HOSPITAL:	277		OTHE	R:	4.00					
Ŧ	27. MANNER OF DEATH	28a. DATE OF IN	JURY	28b. TIMI	OF	2Sc. INJU		Bidence	6 Other (Specify) 28d. DESCRIBE HOW I	NJURY OC	CURED	
ву Р	1 Natural 5 Pending	(Month, Day,	Year)	INJ	JRY M	WO		NO	- S - S - S - S - S - S - S - S - S - S		-51126	
	2 Accident Investigation 3 Suicide S Could not be	28e. PLACE OF I	NJURY — At hor	me, farm, s	treet, fac	tory, office			281. LOCATION (Street a	and Number	or Rural Route	Number.
三三	4 Homicide determined	building, etc	z. (Specify)						City or Town, State)			
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of m	knowledon de	th occurre	d at the t	time data	and elec-	and due	to the cause(a) and mar			
M									to the cause(a) and mar time, data and placa, an			d manner as stated
- 11	290 SIGNATURE AND TITLE OF CERTIFIER		,			1						
BE	< , >	4	lug	e dian			29c. LICE		BEH			inth, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED OFFICE					D146	026		J	uly 19	, 1995

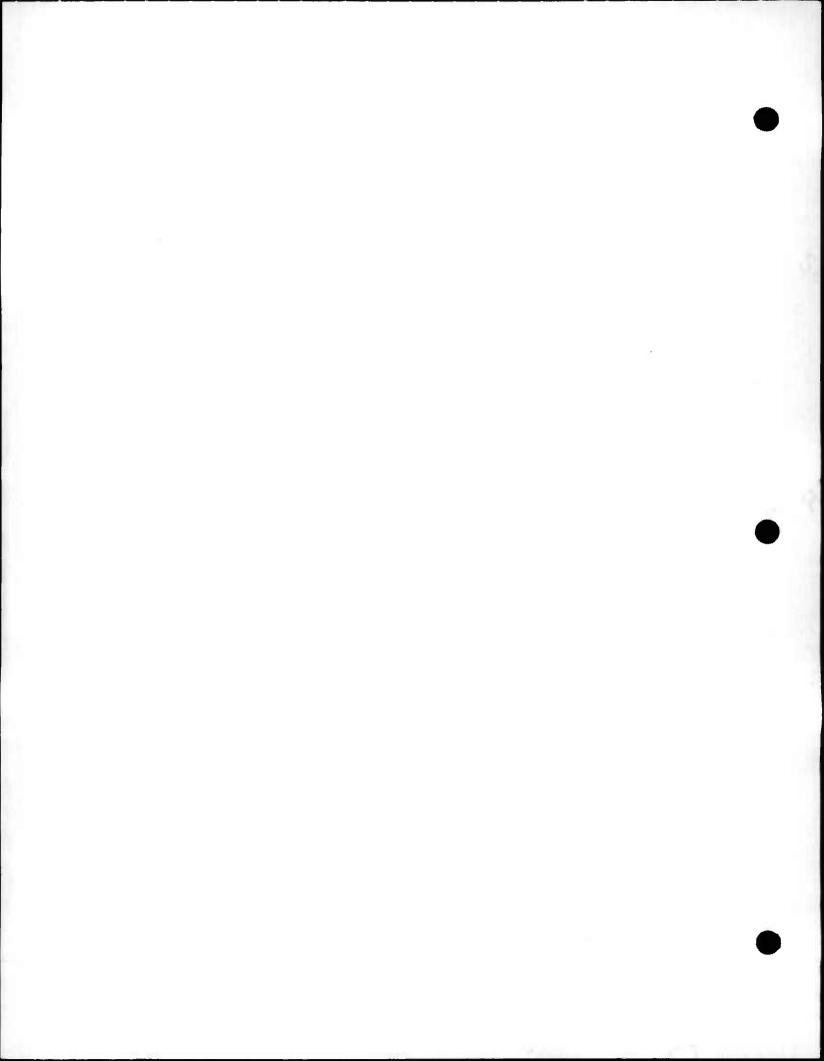
Dr. P. Gregory Rausch, M.D., 501 West Seventh Street, Frederick, MD 21701
31. DATE FILEO (MORITH, Day, 1967)

JUL 2 1 1995

32. REGISTRAR'S SIGNATURE

JUL 2 1 1995

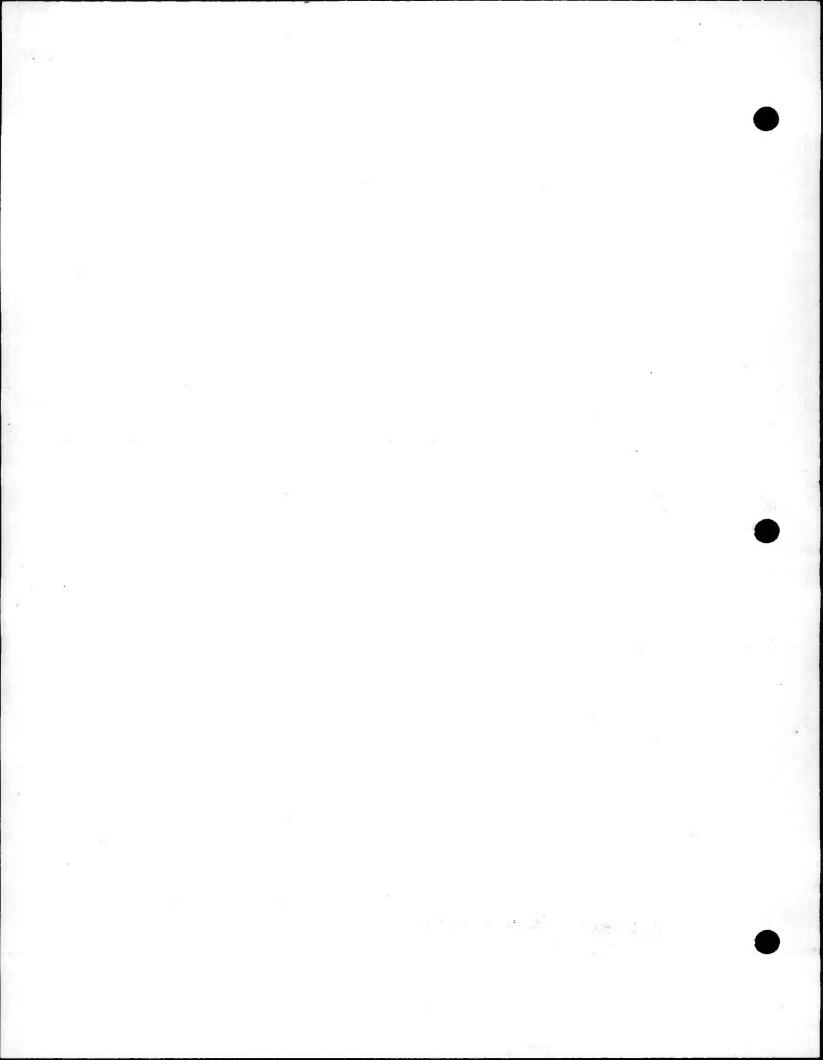
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



	1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF HEALTH AN	D MENTAL HYGIEN REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last) THOMAS BROWI	,			2. DATE OF DEATH MONTH 0 7 1	5 1995	3. TIME OF DEATH 02:10 A
	4. SOCIAL SECURITY NUMBER 579-76-4497 98. FACILITY NAME (# not institution, give si	1 X M 2 □ F	38 YRS. M	F UNDER 1 YEAR IF UNDER 24 HF DAYS HOURS MH	DEC. 18,	1956 ^{coum}	
стоя	2202 WINTERGRI			b. city, town or location of DISTRICT HE		9c. COUNTY OF I	E GEORGE
DIREC	10a. STATE 10b. COUNTY	ince George		OVER TOWN OR LOCATION			10d. INSIDE CITY LIMITS? 1 . YES 2 NO
ERAL	100. STREET AND NUMBER 5515 Marlboro			10f. ZIP CODE	747	10g, CITIZEN OF	WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DAT	U.S. ARMED 2 NO	13. WAS DECENDENT OF HIS If yes, specify Cuban, Ma 1 YES 2 NO Sc		a or No- 14, RAC	E - American Indian, k, Whita, atc.
APLETED	15. DECEOENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12) 1.2 th	CATION	16a. OECEDENT'S US (Give kind of won life. Do NOT use n	done during most of working		siness/industry	
BE COMPL	17. FATHER'S NAME (First, Middle, Lest) Thomas Brown				NAME (First, Middle, Melder		
TO	19a. INFORMANT'S NAME (Type/Print) Rarbara Rr 20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remo 4 Donation 5 Other (Specify) 11. SIGNATURE OF FUNERAL BERVICE LIC	oval from Stata 20b. F	5515 A	osposition (Name of Veteran Cer	#12 Fores	ctville. CATION - City or to Cheltenh	am, MD.
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	CIRRHOSIS OF DUE TO (OR AS A COURT TO (OR AS A C	THE LIVER CONSEQUENCE OF:			7401	Interval Betw Onset and D
MEDICAL	PART II. Other aignificant conditions DID TOBACCO USE CONTR				YYES :	IMEO?	WERE AUTOPSY FINDS AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ¬YES 2 NO		B. PLACE OF DEATH (
ву Рну	27. MANNER OF DEATH 1 MNetural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME D INJUR	F 28c. INJURY AT	28d. DESCRIBE HOW	NJURY OCCURED	
ETED E	3 Suicide 6 Could not be 4 Homicide datermined	26s. PLACE OF INJURY – building, etc. (Specify	- Al home, term, stre	et, factory, eHice	261. LOCATION (Street City or Town, Stete)	and Number or Rural I	Route Number,
COMPLI				it the time, data and place, and in my opinion, death occured at			i) and menner as state
		11 11/2 1		29c. LICENSE	NUMBER	29d, DATE SIGNED	
TO BE	29h SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	Lolly A)	H (ITEM 27) (Type, Pri	0.C.N	1.E.	▶ 07-	(Month, Day, Year) 15 – 1995

DIVISION OF VITAL RECORDS, P.O. BOX 68760 SEBALTIMORE, MARYLAND 21215-0020

DHMH-16 Rev 1/89



TO THE HOSPITAL OF ATTENDION OF WINDOWS THE WINDOWS THAT THE HOSPITAL OF ATTENDION OF ATTENDION PROPERTY THE WINDOWS THE WINDOWS ATTENDION OF ATTEND	the forther between meaning continger to be soon agreed by the actioning profession company, more by the decide of the profession of the p
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COMPLETED 28

> BE 5

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH BERNIC 1 = 20 Am JULY-4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year) Feb. 18, 73 578-20-8934 1 M 2 X F HOURS 1922 Wash. 96. FACILITY NAME (If pot institution, give street and number)

MANOR CARE 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Largo. RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY D.C. Washington 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4217 East Capitol Street S.E. 20019 USA 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cubsn, Mexican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Divorced 1 TES 2 NO Specify: Specify: BY Black COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ntary/Secondary (0-12) College (1-4 or 5+) Industrial Control Tech U.S. Government 1 yr 17. FATHER'S NAME (First, Middle, Last)
Merrill A. Swann 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elsie Brown BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Millicent Barnes 2420 Corning Ave. # 103 Ft. Washington, Md. 20744 20a. METHOD OF DISPOSITION
1 IX Buriel 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State ry, crematory or other plece)
Lincoln Cemetery 4 Donation 5 Other (Specify) Brentwood, Md 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home 4217 9th. St. N.W. Wash. D.C. 20011 23. PART I Enter the diseases, or complicatione that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feilura. List only one cause on each line. interval Between **Onaet and Death** IMMEDIATE CAUSE (Final disease or condition TAGE CARCINOMA OF LUNG reaulting in death) CERTIFICATION Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSPOUENCE OF): thet initiated evante resulting in death) LAST PART ii. Other eignificent conditions contributing to death but not recuiting in the underlying ceuse given in Part i. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO PHYSICIAN: MEDICAL

She was	DS- DNF			1 D YES 2 000	COMPLETION OF CAUSOF DEATH?
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpatient	3 DOA 4 X	26. PLACE OF DEATH (C		
27. MANNER Of DEATH 1 Neturel 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME/OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCU	RED
3 Suicide 6 Could not be	28a. PLACE OF INJURY — At I building, etc. (Specify)	nome, term, street, 1a	ctory office	261, LOCATION (meet and Number or City or Town, (man)	Rural Route Number,

29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated.

MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CENTRER

29c LICENSE NUMBER

8 and	D-34252	107-18-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) S. J. RAO, MD - 4000-Mthol VIII	Road + 220; 1	10 - Boure-20716

31. DATE FILED (Month, Day, 1981)

32, REGISTRAR'S SIGNATURE

28d DATE SIGNED (Month Day Your)

retained by the hospital or attending physician. **BALTIMORE, MARYLAND 21215-0020** hours after death. Page 6 may be DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with and TO THE HOSPITAL OR ATTENDING PHYSICIA
TO THE FUNERAL DIRECTOR: After this certif
be filed within 72 hours after death with the
IMPORTANT: It Item 28 is marked, or

funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should ಸ notified pe must medical examiner completely filled in by the rial, cremation, or removal. cremation, or the other traumatic event, Hygiene prior to burial, the attending physician Mental Hygiene prior to 5 Health and 23 shows any this certificate has been with the State Dept. of 0 the

MEDICAL CERTIFICATION

PHYSICIAN:

BY

COMPLETED

BE

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31. DATE FILED (Month, Day, Year)

95 23139 FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Charles Barranco July 995 Jr 1:40 p 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign Country) 1 XM 2 - F DAYS HOURS 213-07-9889 80 8 - 28 - 14Colorado 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN DIRECTOR Golden Oaks Nursing Home Laurel Prince Georges 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince Georges 1 - YES 2 NO Laurel FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9580 Muirkirk Lane, Apt. 201 20708 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE - American Indien, Black, White, etc. 1 Never Married 2 Merried 1 TYES 2 W NO BY Specify: Specify: 3 Wildowed 4 Divorced white COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12 Union Representative United Steelworkers 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Charles Barranco BE Sarah Mario Mannino

196. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. INFORMANT'S NAME (Type/Print) 2 Ethel Barranco Same # 10 as 20a. METNOD OF DISPOSITION
1 D Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 Buriet 2 Cremation 3 4 Donation 5 Other (Specify) Cedar Hill Cemetery 7-119-95 Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY Barranco and Sons Funeral Home 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List pniy one cause on each line. IMMEDIATE CAUSE (Final Onset and Death disease pr condition SOMILE DUE TO (OR AS A CONSEQUENCE OF): resulting in death) YLars Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS PROBABLE COLOMIC AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO 1 YES 2 NO DID TOBÁCCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO MUNCERTAIN

25. WAS CASE REFERRED TO MEDICAL	28. PLAC	CE OF DEATN (Check only one)		
1 YES NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	DOA Nursing Hom	e 5 Residence 6 Other (Specify)	
27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 28c. INJ INJURY WO	RK?	W INJURY OCCURED
3 Suicide 6 Could not be determined	26a. PLACE OF INJURY — At ho building, etc. (Specify)	ome, term, atreet, factory, offic	26t, LOCATION (Stre City or Town, Sta	et and Number or Rural Route Number, ste)
2 MEDICAL EXAMINE	R: On the beals of examination and/or		end place, end due to the cause(a) and n	nanner as stated. and due to the cause(a) and manner as stated.
296. SIGNATURE AND TITLE OF CERTIFIE	a /		29c, LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

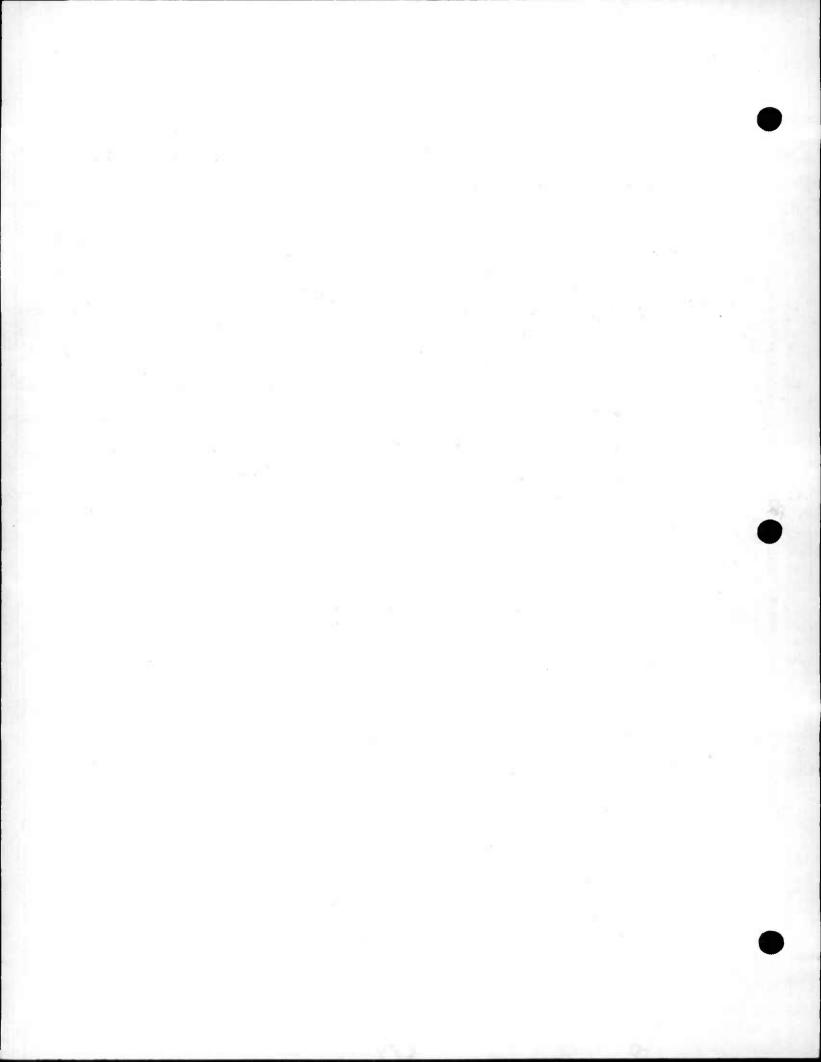
TED CAUSE OF DEATH (TEM 27) (Type, Print)

(YZGLAREL PARK DAILE #

32. REGISTRAR'S SIGNATURE 20 1995 Davidson Rardall

015666

DHMH-16 Rev 1/89



YEAR

9c. COUNTY OF DEATH

New

Anne Arundel

10g. CITIZEN OF WHAT COUNTRY?

United States

1995

3. TIME OF DEATH

7:15A

York

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

Specify: White

1 YES 2 NO

Approximete

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO

COMPLETION DF CAUSE OF DEATH?

1 TES 2 NO

29d. DATE SIGNED (Month, Day, Year)

18-9

interval Between

Onset and Daath

8. BIRTHPLACE (State or Foreign

BALTIMORE, MARYLAND 21215-0020	4 hours after death, Page 6 may be retained by the hospital or attending physici	filled in by the funeral director, page 5 should be detached for use as the burial-
DIVISION OF VITAL RECORDS, P.O. BOX 68760 SABALTIMORE, MARYLAND 21215-0020	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physici	DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-hours after death with the State Deot, of Health and Mental Hyglene prior to burial, cremation, or removal
	R	DIR

296. SIGNATURE AND TITLE OF CER

TONY

AND ADDRESS

JUL 19 1995

BE

2

FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH eigh July 12 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) Jan 2 1920 8. AGE (In yrs. last birthday) DAYS XXX 2 - F 069-03-4088 75 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Meridian Health Care Ctr. Spa Creek Annapolis RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD Anne Arundel Severna Park Dermit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE al-transit 37 St. Andrews Drive 21146 iclan. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X XES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 1 Never Married 2 Married B 3 Widowed 4 Divorced WWII COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade comple 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Sn (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Self-Employed Entrepreneurial 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname notified at Rov Carr Bench BE Isabelle Bills 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 St. Andrews Drive Severna Park, MD 21146 Marv L Bench 2 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Ft. Lincoln Crematory 7/14/95 Brentwood, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD medical 23. PART I. Enter the disesses, or complications that caused the daeth. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, shock, or heart fellure. Liet pnly pna cause pn eech line. IMMEDIATE CAUSE (Fine) the disesse pr condition MAG resulting in desth) event. other traumatic MEDICAL CERTIFICATION of auni Sequentially list conditions, QUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in death) LAST 0 Injury, PART II. Other eignificant conditions contributing to daeth but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? shows any 1 - YES 2 X NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)item **EXAMINER?** 1 YES 2 NO OTHER! 1 Inpetient 2 ER/Outpetient 3 DOA ursing Home 5 - Residence 6 - Other (Specify) 6 27, MANNER OF BEATH 200. DATE OF INJURY 28b. TIME OF 26c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED marked. Mitural 1 YES 2 NO В Accident Investigation 3 Suicida 26f. LOCATION (Street and Number or Rural Route Number, City or Yown, State) 28s. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 28 is COMPLETED 8 Could not be 4 Homicide TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2 29a. CERTIFIER (Check only

F PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

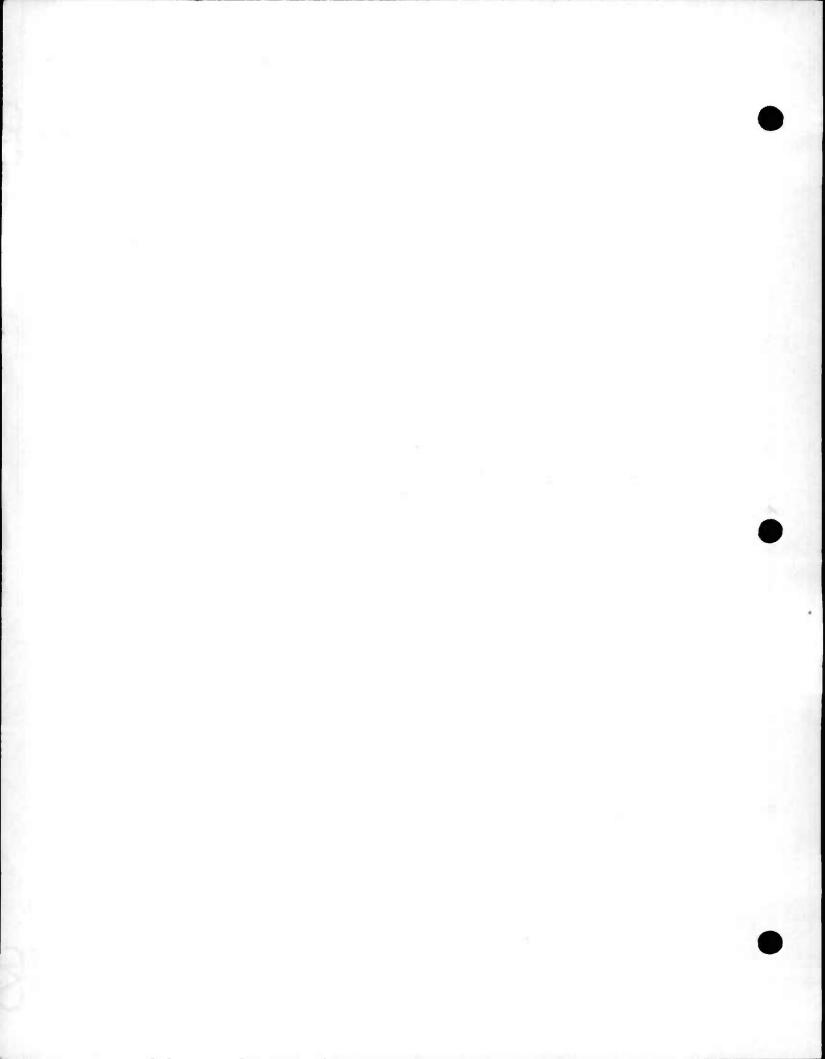
32 REGISTRAR'S SENATURE

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(e) and manner ee stated.

ion and/or investigation, in my opinion, death occured at the time, date

29c. LICENSE NUMBER

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



NDING PHYSICIAN: The law requires that the death certificate be executed within 24
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached thruss as the hurial-transit permit Panes 1.2 a should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal,
IMPORTANT If item 28 is marked on item 23 shows any injury or other trainmaft; event the market as assistant as assistant as asset

Paul Snow, M.D.

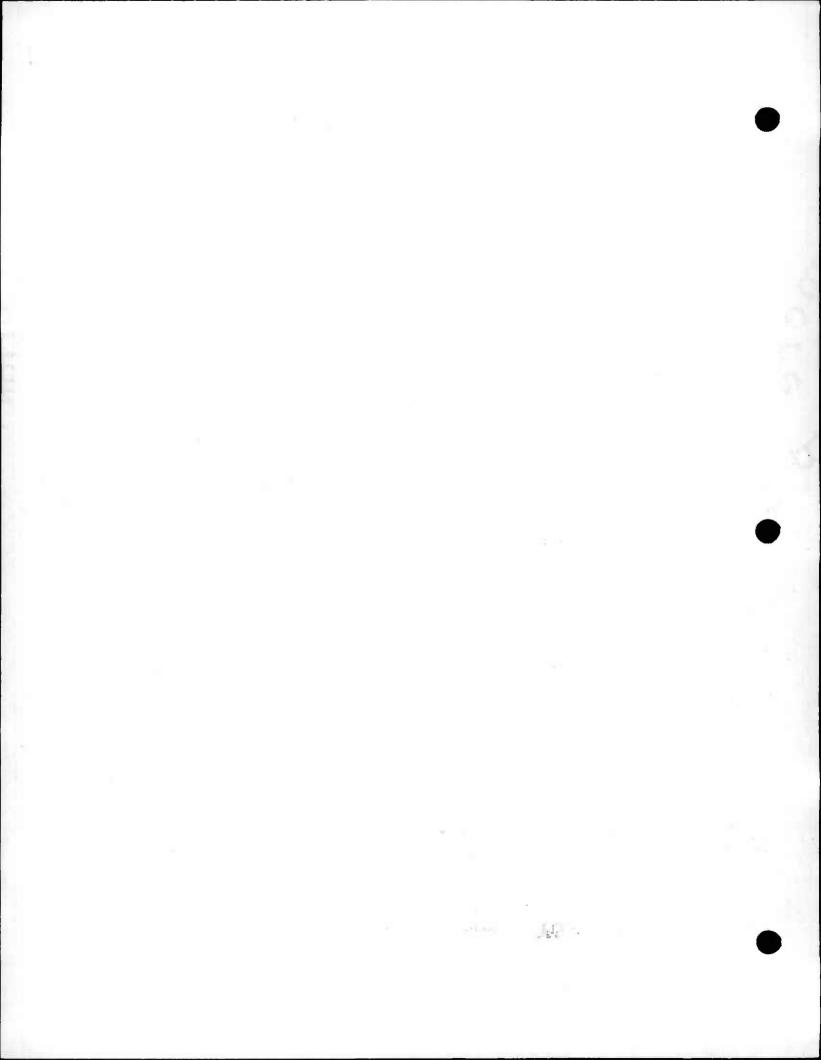
31. DATE FILED (Month, Day, Year)

JUL 18 1895

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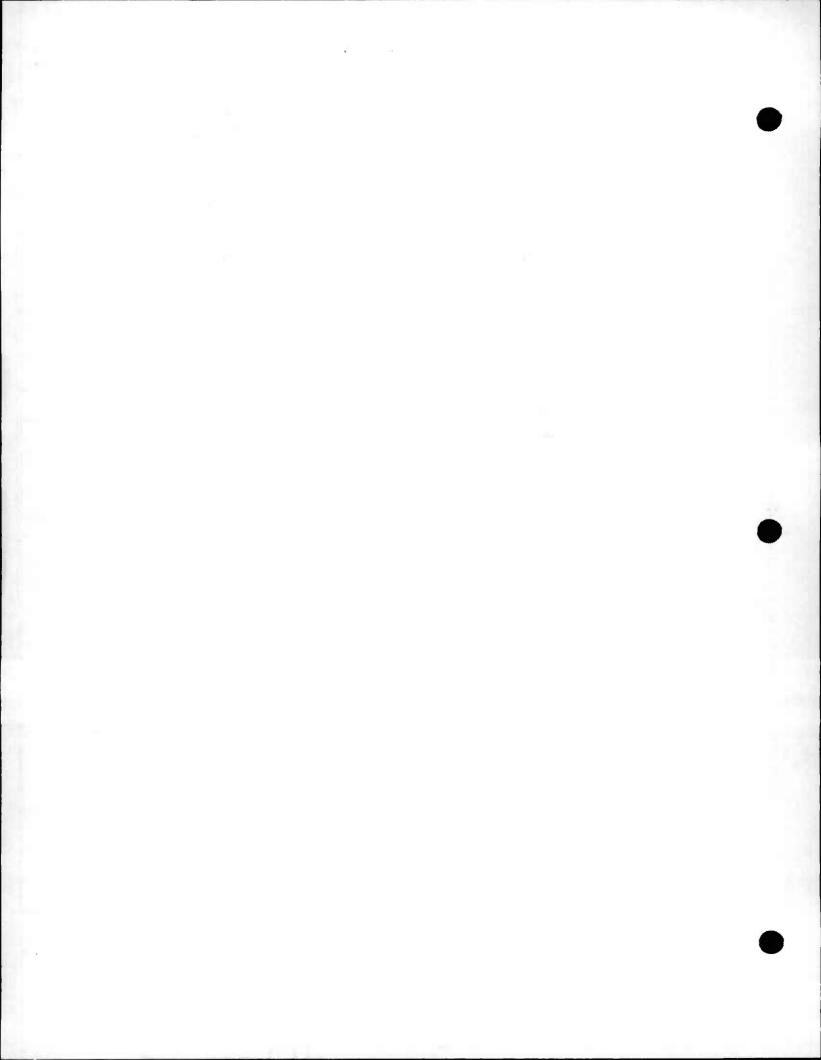
											95	2314	1
	1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR	RTMEN	T OF H	IEALTH DE AT	AND	MENTAL HYGIE				
	REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH												
	Anna M Bittner							July 15,	10:21AM				
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	et hirthriau)	IE I IMPA	ER 1 YEAR	IF UNDER	OA MOR	7. DATE OF BIRTH	1993	Lanuari		М
	214-05-9835	1 🗆 M 2 💢 F	91	YRS.	MONTHS	1	HOURS	MIN.	July 13,	100/	West	IPLACE (State or Fon	-
	9e. FACILITY NAME (If not institution, give s		71	Tho.			- 11						
· c	Memorial Hospital			OR LOCATE	ON OF DE	EATH	EATH						
ΙĒ	Memorial Hospital Cumberlan									A.	llega	iny	
DIRECTOR	10e. STATE 10b. COUNT	100 CIT	v mann	OR LOCAT	TION:					=			
E	West Va Min			ION		10d. INSIDE CITY LIMITS?							
	10e. STREET AND NUMBER	age	ley						1 X YES 2 - N	ю			
\ <u>\\</u>	17.0 Mark 1997 CODE 16g, CITIZEN OF												
買	172 Main Stree						267	53		l u	.S.A	. F	
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDEN	TEVER IN U.S. AR	MED	13	WAS DEC	ENDENT C	F HISPAN	HC ORIGIN? (Specify Year, Puerto Rican, etc.)	e or No-	14, RACE	E — American Indier	١,
₽	3 Widowed 4 Divorced	IF YES, GIVE V	MAR OR OATES				2 NO	Specify				45	
		l										White	
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade	completed)	/G	CEDENT'S	work done	during mo	ON ist of workin	ng	16b. KIND OF BU	SINESS/INDUSTRY			
"	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Do NOT u		,							
Ξ	10			omen	аке	r.			Home				
18	17. FATHER'S NAME (First, Middle, Last)								ME (First, Middle, Meider	,			
BE	Charles T. Ede	nnart					An	n a	B. Nicke	1			
2	19e. INFORMANT'S NAME (Type/Print)								Poute Number, City or Tox				
-	James Preaskorn 106 Luteman RdCumberland, MD 21502												
	206. METHOD OF DISPOSITION 206 PLACE AND DATE OF DISPOSITION (Name of												
	1 X Burial 2 cremation 3 Removal from State 4 Donation 6 Other (Specify) Hillcrest Burial Park 1/8/95 Cumberland, MD												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE												
TO BE COM	George-Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, MD 21502										2		
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errors.												
	strock, or neart failure. List only one cause on each line.												
	IMMEDIATE CAUSE (Final disease or condition										Onsat snd	Death	
	resulting in death) a. Coronary artery heart disease											Uk yrs	
	DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions,	DUE TO	OR AS A CONSE	DIENCE O	ED-								
A	if sny, leading to immediata cause. Entar UNDERLYING	If any, leading to immediate											
윤	CAUSE (Disease or Injury that Initiated events	OUE TO	(OR AS A CONSEC	NIENCE O	n.								
Ē	resulting in death) LAST		(or no h oorloge	action of	,.							i	
Ü	d												
T	PART II. Other significant condition	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS											
2	Aortic stenosis/ Mitral valve dynfunction PERFORMED, AMALABLE PRIOR TO COMPLETION OF CAME												
8			raive ay	ST GII		/11			1 TES	NO	- 1	OF DEATH?	
Σ	DID TORACCO LISE CONTE	VIDLITE TO CA	LICE OF DEA	T11 \/			C					1 TYES 2 NO)
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTE	CIDUIE IU CA					UNC	ERTAIN	ч Ц				
0	EXAMINER?	HOSPITAL:	1	E OF DEAT	OTHE								
ΥS	1 YES 2 NO	1 Inpetient 2			4 🗌 Nu	raing Hom		sidence	6 Other (Specify)				
표	27. MÄNNER OF DEATH Netural 5 Pending	28e. DATE OF (Month, D		28b. TIM INJ	URY	28c. INJ WO	URY AT RK?		28d. OEŞCRIBE HOW	INJURY OC	CURED		
À	2 Accident Investigation				М		'ES 2 [NO					
	3 Suicide 8 Could not be	28a. PLACE O building,	FINJURY At hor stc. (Specify)	ma, farm, a	straat, fac	tory, office			26f. LOCATION (Street City or Town, State,	end Numbe	r or Rural R	bute Number,	
	4 Homicide determined								, ionn, state,				
COMPLETED	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the beat of	my knowledge, da	ath occurre	d at the	time, dete	end place.	end dus	to the cause(a) and me	nner es et-	ted.		
M	one) 2- MEDICAL EXAMINE											and menner as at-	terf
	296 SIGNATURE AND TITLE OF CERTIFIER					1	_						eu.
H	OF CENTIFIER		T)		9		29c. LICE					(Month, Day, Year)	
2	Dpty Med Ex D 09157 July 15, 1995												

24 w 3rd st Cumb Md 21502



	pin	
DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020 LA	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 and the found after the function of the intended by the attending physician and completely filled in by the functal director, page 5 should be detached for use as the burial-transit permit Ages 1. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Lest)		BERTIE	2. DATE OF DEATH		3. TIME OF GEATH						
- 3	Clarence J.	•		Bailev		July	1 190	25 2:03 A M				
Į,		SURITY NUMBER 5. SEX R. AGE (In yes last high-day) IS IMPER 4 YEAR IS IMPER 4 ARE						BIRTHPLACE (State or Foreign Country)				
		1 XM 2 - F	83 YRS.	MONTHS DATS	HOURS MIN.	Jan. 8, 19						
~	9a. FACILITY NAME (If not institution, give stre			F-10	OR LOCATION OF D							
Ē	Easton Memorial H	lospital		Easton		Talbot						
DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	ION			10d. INSIDE CITY				
	Maryland Tall	oot	Tr	appe			LIMITS? 1 ☐ YES 2 🖔 NO					
₹ AL	10e. STREET AND NUMBER				ZIP COOE		10g. CITIZEN	OF WNAT COUNTRY?				
FUNERAL	4731 White Marsh			21673		USA						
ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	N U.S. ARMEO 2 [X] NO ATES	13. WAS DEC If yes, spi 1 YES	ENDENT OF HISPA ecity Cuben, Mexico 2 A NO Specia	NIC ORIGIN? (Specify Yea an, Puerlo Rican, etc.) ly:	fea or No— 14. RACE — American Indian, Black, White, atc. Specify: Black						
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION ompleted)	16a. DECEDENT'S	USUAL OCCUPATIO	ON starting	16b. KIND OF BUS	BUSINESS/INDUSTRY					
	Elementary/Secondary (0-12)	College (1-4 or 5 +)		work done during mo se retired.)	at or working							
MP	17. FATHER'S NAME (First, Middle, Last)		Porter					& Clothiers				
၁	George Bailey					AME (First, Middle, Maiden	Surname)					
BE	19a. INFORMANT'S NAME (Type/Print)		19h MAII ING	ADDRESS (Street o		Boute Number, City or Town						
2	Georgia Etta Hai	lstalk), Trappe,						
	20e_METHOD OF DISPOSITION 1 ABurial 2 Cremation 3 Remov	rel from State cen	PLACEAND DATE (petery, crematory or o Paradise	OF DISPOSITION (Na	me of	OATE 20c. LO						
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIGE		raradise				/95Trappe, Md.					
- 8	Bennie Smith Funeral Services											
щ	An DARTHE H					87, Easton						
	23. PART I. Enter the diseases, or co shock, or heart failure. Li	mplications that caused ist only one cause on e	d the death. Do r ach line.	ot anter tha mo-	da of dying, suc	ch aa cardiac or reapi	atory arrest,	Approximata interval Between Onset and Death				
	IMMEDIATE CAUSE (Finel disease or condition											
	disease or condition reaulting in death) a. Cenhoves suler Infanction OUE TO (OR AS A CONSEQUENCE OF): A there is leading to immediate Due TO (OR AS A CONSEQUENCE OF):											
z	Advance leading Diseases											
CERTIFICATION	Cause, Enter UNDERLYING CAUSE (Disease or Injury											
2												
Ē	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):										
W	d											
O	d.											
AL C	PART II. Other algnificant conditions	contributing to death b	ut not resulting	in the underlying	cause given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO				
CAL	A7-20 +	contributing to death b	ut not resulting	,	j cause given in	Part I. 24a. WAS AN PERFORI	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
MEDICAL	Air il t	wi Hee	14 t	aiture		PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE				
MEDICAL	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	F DEATH YE	àiture s 🗆 NO 🗆		PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
MEDICAL	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	BUTE TO CAUSE O	F DEATH YE	S NO THER:	UNCERTAI	PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
MEDICAL	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	BUTE TO CAUSE O	F DEATH YE 26. PLACE OF OEAT estient 3 □ DOA	S NO OTHER: 4 Nursing Homise OF 28c. INJI	UNCERTAII	PERFORI	MED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNED OF DEATH 1 Netural 5 Pending	BUTE TO CAUSE O	F DEATH YE 26. PLACE OF OEAT estient 3 □ DOA	S NO THER: A Number House Hous	UNCERTAII	PERFORI	MED?	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 YOO 27. MANNED OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be	BUTE TO CAUSE O	F DEATH YE 26. PLACE OF GEAT DOTALL STATE OF STA	S NO THER: A Nursing Hom. WO 1 1 Y	UNCERTAII	PERFORI	NO NO NO NO NO NO NO NO NO NO NO NO NO N	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNED OF DEATH 1 Netural 5 Pending 1 Investigation 3 Suicide 8 Could not be detarmined	BUTE TO CAUSE O HOSPITAL: 1 Drippitlant 2 = ER/Outp 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Spec	F DEATH YE 26. PLACE OF OEAT estlant 3 DOA 28b. TIM HNJ	S NO THER: 4 Nursing Hom. E OF 28c. INJ. WO 1 Y WO 1 Y VICTOR OFFICE	UNCERTAII 5 G Raeldenca JRY AT RK7 ES 2 G NO	8 Other (Specify) 28d. DESCRIBE HOW IN City or Town, State)	JURY OCCURE	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNED OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only)	BUTE TO CAUSE O HOSPITAL: 1 Impartient 2 = ER/Outp (Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Spec	F DEATH YE 26. PLACE OF OEAT estient 3 DOA 28b. TIM (IN) — At home, farm, s	S NO THER: 4 Nursing Hom. E Of URY WO 1 Y WO street, factory, office	UNCERTAII 5 Grandenca JRY AT RK? ES 2 Grandenca and placa, and due	8 Other (Specify) 28d. DESCRIBE HOW IN City or Town, State)	JURY OCCURE	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNED OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be 4 Homicide detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	BUTE TO CAUSE O HOSPITAL: 1 Impartient 2 = ER/Outp (Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Spec	F DEATH YE 26. PLACE OF OEAT estient 3 DOA 28b. TIM (IN) — At home, farm, s	S NO THER: 4 Nursing Hom. E Of URY WO 1 Y WO street, factory, office	UNCERTAII 5 Grandenca JRY AT RK? ES 2 Grandenca and placa, and due	8 Other (Specify) 28d. DESCRIBE HOW IN City or Town, State)	JURY OCCURE	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNED OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only)	BUTE TO CAUSE O HOSPITAL: 1 Impartient 2 = ER/Outp (Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Spec	F DEATH YE 28. PLACE OF OEAT estient 3 DOA 28b. TIM 18h) — At home, farm, s ledge, death occurre on end/or investigation	S NO THER: 4 Nursing Hom. E Of URY WO 1 Y WO street, factory, office	UNCERTAIN 5 Residence JRY AT RK7 ES 2 NO and place, and due anth occured at the	8 Other (Specify) 28d. DESCRIBE HOW IN City or Town, State) to the cause(a) and many ilma, date and place, and	JURY OCCURE Ind Number or R There as stated, I due to the ce	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
E COMPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNED OF DEATH 1 Netural 5 Pending 1 Netural 1 Pending Investigation 2 Accident 1 Could not be detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	BUTE TO CAUSE O HOSPITAL: 1 "Impettent 2 = ER/Outp 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Spec	F DEATH YE 26. PLACE OF OEAT 28b. TIM INJ — At home, farm, s ledge, death occurre in end/or investigation	S NO CHARGE OF NO STREET, Factory, office and at the time, data no, in my opinion, do	UNCERTAIN 5 Residence JRY AT RK7 ES 2 NO and place, and due anth occured at the	8 Other (Specify) 28d. DESCRIBE HOW IN City or Town, State) to the cause(a) and mani-	JURY OCCURE Ind Number or R There as stated, I due to the ce	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO D Ural Route Number,				
BE COMPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNED OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be 4 Homicide detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	BUTE TO CAUSE O HOSPITAL: 1 "Impettent 2 = ER/Outp 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Spec	F DEATH YE 26. PLACE OF OEAT 28b. TIM 28b. TIM 18h. At home, farm, a iedge, death occurre in end/or investigation ATH (ITEM 27) (Type,	S NO CHARGE OF NO STREET, SECTORY, OFFICE OF URY M 1 YOUR STREET, SECTORY, OFFICE OF OFFICE O	UNCERTAIN 5 GRaeldenca JRY AT RK? ES 2 GNO and place, and due and place, and due and place at the	8 Other (Specify) 28d. DESCRIBE HOW IN 28f. LOCATION (Street a. City or Town, State) to the cause(a) and manifold the cause(a) and manifold the cause (a) and manifold the cause (b) and manifold the cause (c) and manifold the couse (c)	JURY OCCURE Ind Number or R There as stated, I due to the ce	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO D Ural Route Number,				
BE COMPLETED BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	BUTE TO CAUSE O HOSPITAL: 1 Diripettent 2 ER/Outp 28a. DATE OF INJURY (Month. Day, Year) 28a. PLACE OF INJURY building, etc. (Special Completed Cause of examination COMPLETED CAUSE OF DE. Memorial 32. BEGISTRAR'S SIGN.	F DEATH YE 26. PLACE OF OEAT 26b. TIM 28b. TIM At home, farm, a iedge, death occurre a end/or investigatio ATH (ITEM 27) (Type, Hospital	S NO CHARGE OF NO STREET, SECTORY, OFFICE OF URY M 1 YOUR STREET, SECTORY, OFFICE OF OFFICE O	UNCERTAIN 5 GRaeldenca JRY AT RK? ES 2 GNO and place, and due and place, and due and place at the	8 Other (Specify) 28d. DESCRIBE HOW IN 28f. LOCATION (Street a. City or Town, State) to the cause(a) and manifold the cause(a) and manifold the cause (a) and manifold the cause (b) and manifold the cause (b) and manifold the cause (c) and manifold the couse (c)	JURY OCCURE Ind Number or R There as stated, I due to the ce	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO D Ural Route Number,				

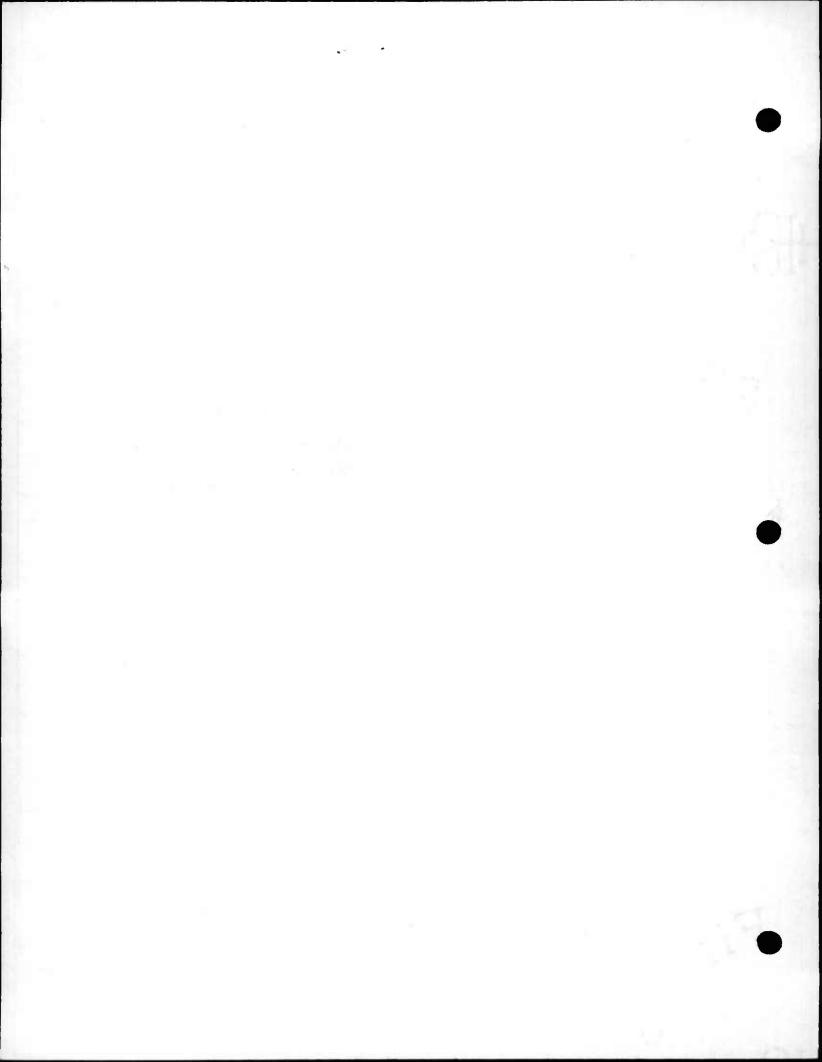


TO THE HOSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ear hours after death. Page 6 may be retained by the hospital or attending physician.	10 THE FUNEMAL DIRECTOR: After this certancate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. or Health and Memtal Hygeine prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
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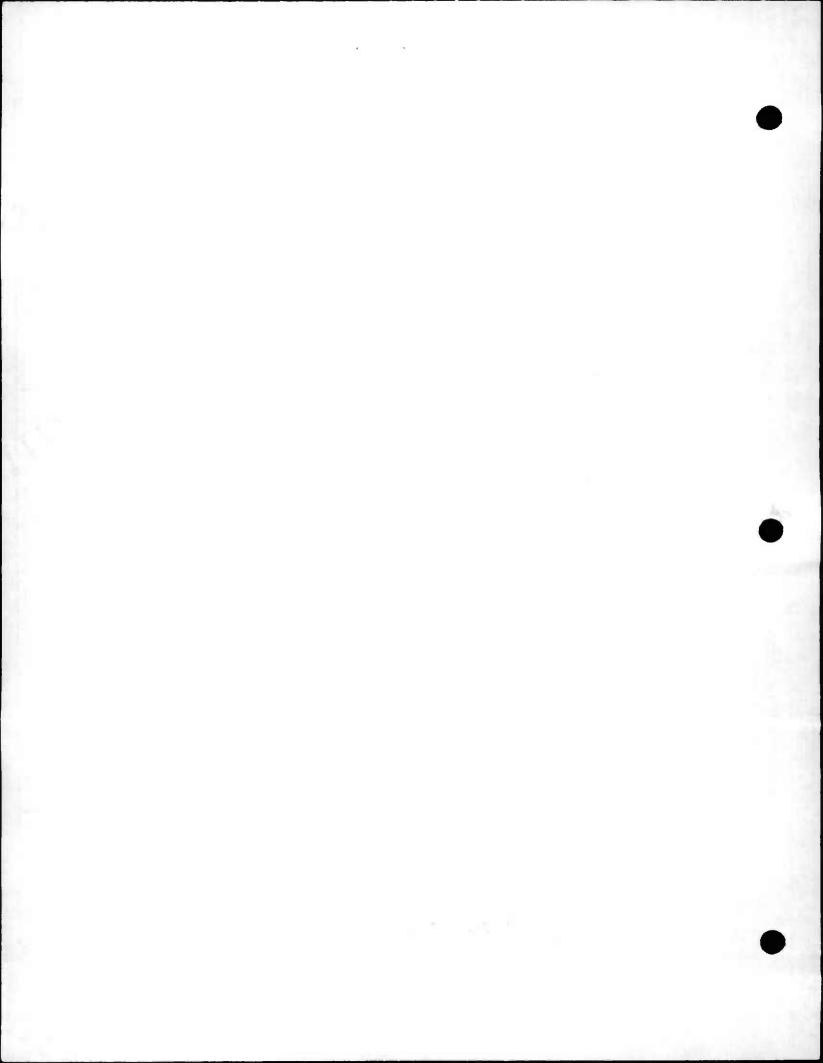
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Lest)	2. DATE OF O						3. TIME OF DEATH		
	AUGUST			Belmont		July 10		12:10 P M		
1			In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)		BIRTNPLACE (State or Foreign Country)		
		XX ^{M 2 □ F} 86	5 YRS.			DEC. 30,1	908 1	NEW YORK		
æ	9e. FACILITY NAME (If not institution, give stree				R LOCATION OF D	EATN	9c. COUNTY	OF DEATH		
18	MEMORIAL HOSPIT	AL		EASTO	ON		TALBOT			
DIRECTOR	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCATE	ION		10d. INSIDE CITY LIMITS?			
		LBOT		EASTON			1 TYES 2 XNO			
A A	10a. STREET AND NUMBER			101.	ZIP CODE	_	10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	27047 PRESQUIL	U.S. ARMED	12 WAS DECS	2160	1 NIC ORIGIN? (Specify Yes		JSA			
	1 Never Married 2 Merried	FORCES? 17 YES	2 NO	If yes, spe	cify Cuben, Mexica	n, Puerto Rican, etc.)	8 OF NO - 14.	RACE — American Indien, Black, White, etc.		
BY	3 XWIdowed 4 Divorced	WW II		1 123	ANO Specif	y.	Specify: WHITE			
TED	15. DECEDENT'S EDUCAT (Specify only highest grade co	ION mpleted)	(Give kind of v	USUAL OCCUPATION	N st of working	16b. KIND OF BU	SINESS/INDUS	TRY		
1 2	Elementary/Secondary (0-12)	College (1-4 or 5+)	IHe. Do NOT us		MALID					
COMPLET	17. FATHER'S NAME (First, Middle, Last)	4	THAFPL	MENT BA		ME (First, Middle, Maiden	NANCIAL			
ш	AUGUST BELMONT	III				E de GOI	,			
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	AOORESS (Street en		Route Number, City or Tow				
F	BROUGHTON M. EAL	RNEST	PIPE	R MARBU	RY, 11	7 BAY ST	, EAS	STON, MD		
	29a, METHOD OF DISPOSITION 1 □ Burlal 2 ▼ Cremetion 3 □ Remova	I from State ceme	PLACE AND DATE O	OF DISPOSITION (Name	me of	OATE 20c. LO		or Town, State		
	4 □ Donetion 5 □ Other (Specify)									
				NEWNA	M FUNE	RAL HOME	, P.A.			
- 1	JOHN K. M	ERCERON	CFSF	> 200 S	HARRI	SON ST.,	EAST	ON, MD		
	23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, abook, or heer feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) Approximate interval Between Onset and Daeth Approximate interval Between On									
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Horo S clordic Vasculor Select									
EDICAL	PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part i, PERFORMED? 1 YES 2 NO 24a. WAS AN AUTOPSY PRIOR TO COMPLETION OF CAUS DF DEATH?									
Σ	DID TOBACCO USE CONTRIE	SUTE TO CAUSE OF	F DEATH YE	SINOI	UNCERTAIL	V PC		1 TES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		8. PLACE OF DEAT		J. TOLITIAN	. ,				
Si		OSBITAL: Inpatient 2 - ER/Outpa	itlent 3 DOA	OTHER: 4 Nursing Home	5 Residence	6 Other (Specify)				
E	27, MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI	E OF 28c. INJU	IRY AT	28d. DESCRIBE NOW I	ESCRIBE NOW INJURY OCCURED			
B	1 Natural 5 Pending 2 Accident Investigation				ES 2 NO					
ETED	3 Suicide 8 Could not be determined 28. PLACE OF INJURY — At home, ferm, street, tectory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
COMPLETE		N: To the best of my knowled On the basis of examination						ouse(e) end menner ee stated.		
BE C	296. SIGNATURE AND TITLE OF CERTIFIER			2.0	29c. LICENSE NUM	MBER	29d. DATE SI	GNED (Month, Day, Year)		
2	Jufai		21	n)	D1531	5	> 7	-10-95		
	THOMAS W. FAUNTI	EROY, M.D	., 403		COURT	, EASTON.	MD 2	21601		
	31. DATE FILED (Month, Day, Year) JUL 11 1995	32 AEGISTRAR'S SIGNA	TURE							

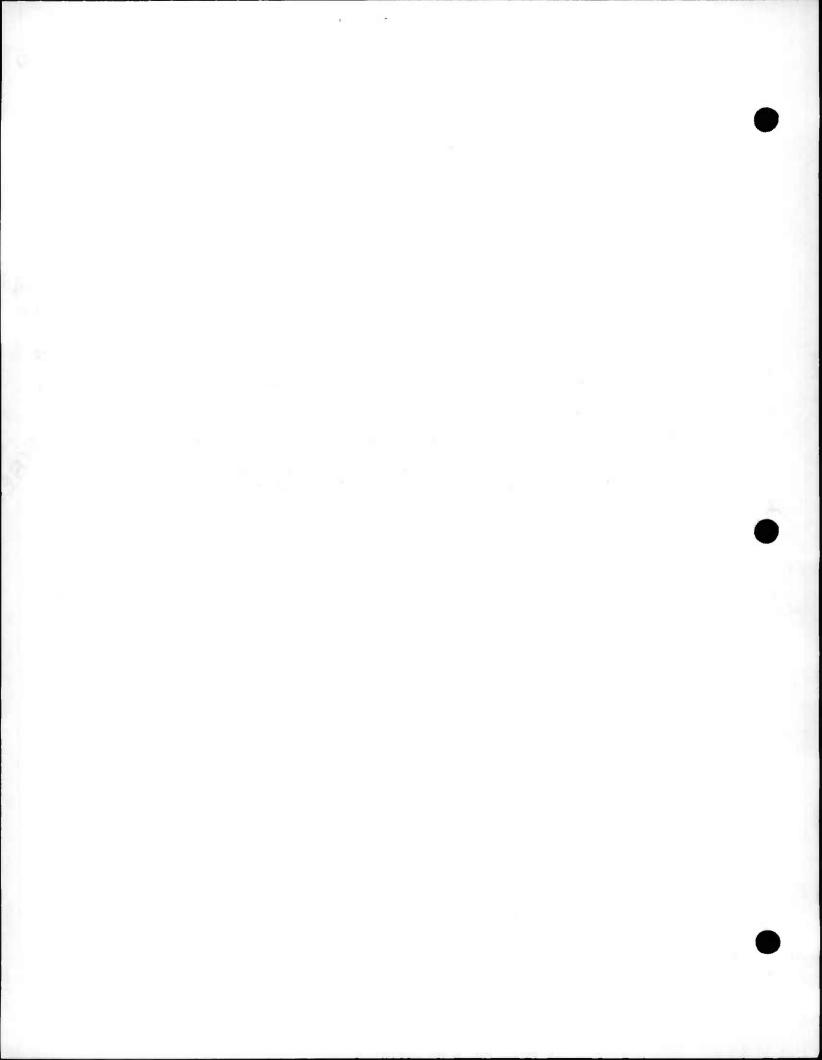


		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPA CERTA	ARTMEN	T OF H E OF	DEAT	AND ME	NTAL HYGIE REG. N			
		1. DECEDENT'S NAME (First, Middle, Last)	E Bynu						DATE OF DEATH		YEAR 3	TIME OF DEATH
	ЕСТОЯ	4. SOCIAL SECURITY NUMBER 237-52-3486	5. SEX 6. AGE	(In yrs. lest birthde		DAYS	IF UNDER	24 HRS. 7. MIN.	DATE OF BIRTH (Month, Day, Year)	2-7	. BIRTHPL Country)	ACE (State or Foreign
3 should										9c. COUNT		in nove.
s 1, 2,		RESIDENCE OF DECEDENT 100. STATE 100. COUNT	ν	100	ITY, TOWN					, ,		
permit. Pages	DIR	Maryland Ker			Cheste							Od. INSIDE CITY LIMITS? X YES 2 NO
	3AL	10e. STREET AND NUMBER		-		101	. ZIP CODE	E		10g. CITIZE		AT COUNTRY?
020 physiclan, burial-transit	FUNERAL	138 Prospect St.	12. WAS DECEDENT EVER II	NUL ADVICE			21620			US		
the the	BY	1 Never Married 2 Married 3XXWidowed 4 Divorced	FORCES? 1 YES	2 X NO		If yes, sp	ecify Cuba 2 2 NO	n, Mexican, P	ORIGIN? (Specify Y varto Rican, atc.)	fas or No— 1	Black, V	- American Indian, White, atc. Black
	TED	15. DECEDENT'S EDU (Specify only highest grade		16a, DECEDENT	of work done	during mo	ON st of workin	g	16b. KIND OF B	USINESS/INDU:	STRY	
	PLET	Elementary/Secondary (0-12) 6th	College (1-4 or 5+)	1	use retired.) ick Dr		_		Bekin	n e		
MARYLAND retained by the hospit 5 should be detached notified at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)						IER'S NAME	(First, Middle, Maide			
MARYLA retained by the 5 should be det outified at on	BE (John Bynum		-				losa B				
	2	190. INFORMANT'S NAME (Type/Print) Myrtle Saunder	's						e Number, City or To Stertown			0
ORE, I 6 may be cror, page 9		20a METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rem	201	. PLACE AND DAT	E OF DISPOS	SITION /Na	me of	, one		OCATION — CH		
MOR age 6 ma director, p		4 Donation 5 Other (Specify)	Ğ	ardens (20/95 R	ocky Mo	unt,	NC
BALTIMORE, ter death. Page 6 may be the funeral director, page oval.		22. NAME AND ADDRESS OF FACILITY Bennie Smith Funeral Home 426 Dover St. Easton, Md. 21601										
in by remedica		23. PARTW Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									Approximate interval Between	
fille fon,		IMMEDIATE CAUSE (Final disease or condition resulting in death)	· Unc	Mhall	0610	P	3)00	dil				Onset and Death
P 0 0 7 0			DUE TO (OR AS A	CONSEQUENCE	OF):	1 -	1	T	110-1/			2
OX 68 e be execut sician and c rior to buri	CERTIFICATION	disease or condition resulting in death) a. Uncontrollaste Bleedity DUE TO (OR AS A CONSEQUENCE OF): Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF):								64		
.O. BOX certificate be ding physician tygiene prior tr	-ICA	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSCOUENCE ON):								24		
, P.O. B eath certifical attending phy mal Hygiene p	H	that initiated evente DUE TO (OR AS A CONSEQUENCE OR): resulting in death) LAST								,		
DS, P the death the atten d Mental H injury, or		PART II. Other significant condition	e contributing to death b	ut not requitio	n in the ur	rderlying		duan in Dan	t 1. 24e, WAS A	AL ALETTO BOLL	T	
ORI s that the ned by lift and any in	MEDICAL				9 111 010 01	- Total yang				PAMED?	AV CC	ERE AUTOPSY FINDINGS WILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?
ITAL REC N: The law requires cate has been sign State Dept, of Heal Item 23 shows		DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH	∕FS □	NO F	LUNC	ERTAIN	ব		11	YES 2 NO
► F 2 8 5 1	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DE	ATH (Check	only one)			=3			
o the title	IYSI	1 VES 2 NO	1 Inpatient 2 ER/Outp			sing Home			Other (Specify)			
N O PHYS	ВУ Р.	1 Netural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	'	IME OF NJURY M		RK? 'ES 2 🗌	NO	d. DESCRIBE HOW			
Z3 TEN	ETED	3 Suicide 6 Could not be datarmined	28a. PLACE OF INJURY building, etc. (Spec	— At home, fam	, street, fact	ory, office	1	26	I. LOCATION (Street City or Town, State		Rural Flout	a Number,
로 작은 =	COMPL		CIAN: To the best of my knowl R: On the basis of axamination									nd menner as stated.
TO THE HOSPI TO THE FUNER be filed within	BEC	29b. SIGNATURE AND TITLE OF CERTIFIER	UI _				29c. LICE	NSE NUMBER		29d. DATE S	IGNED (M	onth, Day, Year)
D D D	2	30. NAME AND ADDRESS OF PERSON WHO	ATH (ITEM 27) /5-	na Priest		D13336				TIL	1195	
	Ì	11.08	MD Cours	or Ce	we f	2			rden, MI		ore	Md.21201
		31. DATE FILED (Month, Day, Year) JUL 1 8 1995	32 REGISTRAR'S SIGN.	ATURS A NOVOLALLY				J. UI	001	DOL CAII	0109	-14.21201



1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIF	ICATE (OF DEATH	REG. NO	O.	
		1. DECEDENT'S NAME (First, Middle, Last)	EANETTE 1	DI OGGDD			2. DATE OF DEATH MONTH	DAY YE	AR 3. TIME OF DEATH
,		4. SOCIAL BECURITY NUMBER		BLOSSER	T .		JULY 13	1995	3:17 PM M
P		217-16-9944	1 □ M 2 🟋 9	(In yrs. lest birthday) 9 YRS.	MONTHS DA		7. DATE OF BIRTH (Month, Day, Year) FEB - 24		BIRTHPLACE (State or Foreign Country) ARYLAND
3 should	· ·	9a. FACILITY NAME (If not institution, give s	treet and number)			WN OR LOCATION OF D	EATH	9c. COUNTY	
1, 2, 3	DIRECTOR	DIXON HOUSE			EA	STON		TA	LBOT
. Sec. 1	<u>ا</u>	10a. STATE 10b. COUNTY	1	10c. CIT	Y, TOWN OR L	OCATION			10d. INSIDE CITY
permit. Pages		MARYLAND TAI	LBOT		EASTO	N			1 X YES 2 NO
Deci	₹	10e. STREET AND NUMBER				101. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
physician. burlal-transit	FUNERAL	108 N. HIGGINS	ST.			21601		US	A
nysicia urial-tr	5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS	DECENDENT OF HISPAI s, specify Cuban, Maxics	NIC ORIGIN? (Specify Y		RACE - American Indian, Black, White, atc.
the hospital or attending physician, i detached for use as the burial-trai once.	B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES	10	YES 2 XNO Specif	y:		Specify: WHITE
al or atter for use a	E	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16e. DECEDENT'S (Give kind of	work done during	PATION g most of working	16b. KIND OF BI	JSINESS/INDUST	RY
d for	Ē	Elementary/Secondary (0-12)	College (1-4 or 5+)	Ilfe. Do NOT us	se retired.)	•			
he hospit detached once.	COMP	17. FATHER'S NAME (First, Middle, Lest)		HOME	MAKER			HOME	
be de	U U	EDWARD ROE				1	ME (First, Middle, Malde		
5 should notified	00	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	AODRESS (Str	eet and Number or Rural	LIE NICHO		
5 st	욘	ANNE N. KIRBY				GGINS ST.			
page the page		20a. METHOD OF DISPOSITION	20b	PLACE AND DATE	OF DISPOSITION	N (Name of		OCATION — City	
ge 6 ma irector, i must		1 X Burial 2 Cremation 3 Remarks 4 Donation 6 Other (Specify)	DE	NTON C	thar place) EMETE	RY	7-17 DEI	NTON,	MARYLAND
death. Pag tuneral di I. examiner		21. SIGNATURE OF FUNERAL SERVICE LIC		4	22. NAM	E AND ADDRESS OF FA	CILITY		
- 2 G		5. Keith	Physpin,	CFSP		WNAM FUNI D S. HARI		•	
d in by the or removal medical		23. PART I. Enter the diseases, or o	complications that caused List only one cause on ea	tha death. Do r	not enter the	mode of dylng, suc	h as cardiac or resp	olratory arreat,	Approximate
ted with the hours completely filled in ial, cremation, or re event, the med		IMMEDIATE CAUSE (Final				11			Interval Between Onset and Death
tely fills mation, t, the		disease or condition resulting in death)	Longes	trie fee	al 1	atture			Imo
ecuted with and on completely fille burial, cremation, affic event, the			DUE TO IGH AS A	CONSEQUENCE OF	0./				
and com o burial.	NO	Sequentially list conditions,	Timer	osclero	523				years
be clan	CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	OUE ICHORAS A	CONSEQUENCE OF	En D	yeare			near
ertificate ng phys giene pi	FIC	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	n/ as	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Jes
eath certifica attending phy ntal Hygiene Y, or other	F	resulting in death) LAST	4	8 9					
the death the atte d Mental injury,	- 11	PART II Other elgolficent condition							
that the ed by the the and In	EDICAL	PART II. Other significant condition	s contributing to death bu	ut not raaulting	In the under	ying causa givan in		RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
uires tha signed ! Health a	ă						1 YES	2 🗆 NO	COMPLETION OF CAUSE OF CEATH?
v requi	Σ	DID TOBACCO USE CONTR	DIPLITE TO CALLER O	F DCATH V	's El No				1 TYES 2 NO
N: The law req icate has been State Dept. of item 23 sho	A	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT			4 🗆 📗		
PHYSICIAN: The law this certificate has with the State Dep rked, or item 23	SICIAN:	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Output	-541	OTHER:	Home 5 Residence	• E • • • • • • • • • • • • • • • • • •		
Sicial certif	ΞI	27. MANNER OF DEATH	26a. DATE OF INJURY	28b. TIM	E OF 28c.	INJURY AT	28d. DESCRIBE HOW	INJURY OCCURE	0
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physi- be fied within 72 hours after death with the State Dept. of Health and Mental Hygiene pri IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other the contractions.	ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	M 1	WORK?			
L DR ATTENDING F DIRECTOR: After to hours after death item 28 is man		3 Suicide 8 Could not be	28a. PLACE OF INJURY building, atc. (Speci	— At home, farm, a	street, tactory, o	offica	28t. LOCATION (Street City or Town, State		ural Route Number,
RECTOR TE		4 Homicide detarmined					only of forth, orang	,	
AL DIRE	IPLE.		CIAN: To the best of my knowle						
HOSPITAL FUNERAL WITHIN 72 H	NO NO	One) 2 MEDICAL EXAMINE	R: On the beals of examination	and/or Investigation	n, in my opinio	n, death occured at the	time, data and place, e	nd due to the car	use(a) and manner as stated.
THE HOSP THE FUNEF filed within PORTANT:	BE	296. SIGNATURE AND THE OF CERTIFIER	1 100			29c. LICENSE NUM	BER	29d. DATE SIG	NED (Month, Day, Year)
5 5 3 X	0	/All	(NI)			DUS	933	D 7.	13.95
		30. NAME AND ADDRESS OF PERSON WHO	SOMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type,	(Print)	ND ZIO	(1)1		
		31. DATE FILED (Month, Day, Mari	62/REGISTRAD'S SIGNA	COS 9	on,	My DI			
		31. DATE FILES (MCTIT), 107701995	12 REGISTRAR'S SIGNA	Rardall					
l l			<u> </u>						



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely find in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should M BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEMS: 23 PART I, II, 27, PER MEO FILM G-726 8/7/95 t.t

		1 - STATE REGISTRAR		STATE OF M	MARYLA					DEA.		MENTA	AL HYGIEN REG. NO			
		1. DECEDENT'S NAME (First, SHIRLE)		JEAN	BAN	IKS	,					MON		w 3,19	YEAR	3. TIME OF DEATH 7:50 A M
		4. SOCIAL SECURITY NUMB 2 1 8 - 3 4 - 8 7		5. SEX	6. AGE (Ir	n yrs. lest i	birthday) YRS.	# UNDE	DAYS	IF UNDE	R 24 HRS.	7. DATI	E OF BIFTH oth, Day, Year)		6. BIRTI Count	IPLACE (State or Foreign
	OR	9a. FACILITY NAME (If not ins 502 FEDERA								SBEI	ION OF DE		, _ , , , , ,	9c. COU	TY OF C	4
	CTO	RESIDENCE OF DEC	EDENT									-				
	DIRE	Maryland		roline			10c, CIT	Y, TOWN	OR LOCA		Fede	era	lsburg	I		10d. INSIDE CITY LIMITS? XXYES 2 NO
	FUNERAL	100. STREET AND NUMBER 502 Fede	ral N	Manor Ap	part	men	ts		10	. ZIP COD		216	3 2			States
	BY	11. MARITAL STATUS 1 X Never Married 2 1 3 Widowed 4 Divor		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES	2 X NO		- 1	If yes, sp	ecity Cubi	OF HISPAN on, Maxican Specify	n, Puerto	IN? (Specify Yes Rican, atc.)	or No—	Bisc	E — American Indian, k, White, etc. ny: Black
			DENT'S EDU			16a. DECI	EDENT'S	USUAL O	CCUPATN	ON ost of worki		16	b. KIND OF BUS	SINESS/IND	USTRY	
må .	COMPLET	Elementary/Secondary (0-		College (1-4 or 5 +	-)	life. E	Do NOT us	ry \	_		ng		Plast	cics		
at once.	BE CO	17. FATHER'S NAME (First, Mic	ddle, Last)	Jaspe	er B	ank	S						Middle Meiden slee I		S	
be notified	TO B	190. INFORMANT'S NAME (Ty) Gregory		c s			MAILING 3 0						nber, City or Tow aurel			956
		20e. METHOD OF DISPOSITION 1 XBurlal 2 Cremation 4 Donation 5 Other	n 3 🗆 Rem	oval from Stata	ceme	PLACE AN	atory or of	her plecel				DA		CATION —		
Je .		21. SIGNATURE OF FUNERAL		ENSEE	<u> </u>	der	al				ery ss of fac		1/] Fed	iera.	ISD	urg, MD
edicai examiner must		> Michae	1 7.	Eskow												eral Home D 21632
Ē		23. PART I. Enter the die shock, or he IMMEDIATE CAUSE (Fin disease Dr condition resulting in death)	art fallure.	a. HYPERTEN	se on aa	ch IIna. CARDI	OVASO	CULAR								Approximeta Interval Batwean Onaet and Death
f, or other traumatic event, the	CERTIFICATION	Sequantially list condition if any, leading to immed cause. Enter UNDERLY!! CAUSE (Disease or injurthat initiated events resulting in death) LAST	liata NG Y	c	(OR AS A (
ws any inju	MEDICAL (PART II. Other algolificar DIABETES ME		a contributing to	desth bu	t not ree	sulting i	n tha ur	derlyln	g cause (given in F	Part I.	24a, WAS AN PERFOR 1 YES 2	MED?	24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
		DID TOBACCO US		RIBUTE TO CA						UNC	ERTAIN					
item	SICIAN:	25. WAS CASE REFERRED TO EXAMINER? Y YES 2 NO	MEDICAL	HOSPITAL:		8. PLACE		OTHER	R:	5 M B	sidence (ar (Paralla)			
0	₽Ħ	27. MANNER OF DEATH		26a. DATE OF (Month, Da	INJURY		28b. TIMI	-	26c. INJ		T T		SCRIBE HOW II	JURY OCC	URED	
man	à B∡	2 Accident tr	ending restigation could not be	28e. PLACE Of	F INJURY -	At home	e, farm, s	M treet, fact		YES 2		261. LO	CATION (Street a	nd Number	or Rural F	loute Number,
1 28 all			etarmined		ore (open)							City	or Town, State)			
2 ==	COMPL			CIAN: To the best of ex) end menner es ateted.
동	ш∥	296. SIGNATURE AND TITLE	de Centrici	100						29c. LICI	ENSE NUM	BER		29d. DATE	SIGNED	(Month, Day, Year)
W.	10 B	30. NAME AND ADDRESS OF	PERSON WHI	COMPLETED CAUS	E OF DEAT	TH (ITEM :	27) (Туре,	Print)			C.M.					14,1995
		31. DATE FILED (Month, Day, N	Cto	HE JK		1 P	enn	St	ree	t, B	alt:	LMO:	re, Ma	aryla	and	21201
		Jul 27	1995	Para Dan	elsor A	artal	6				10					

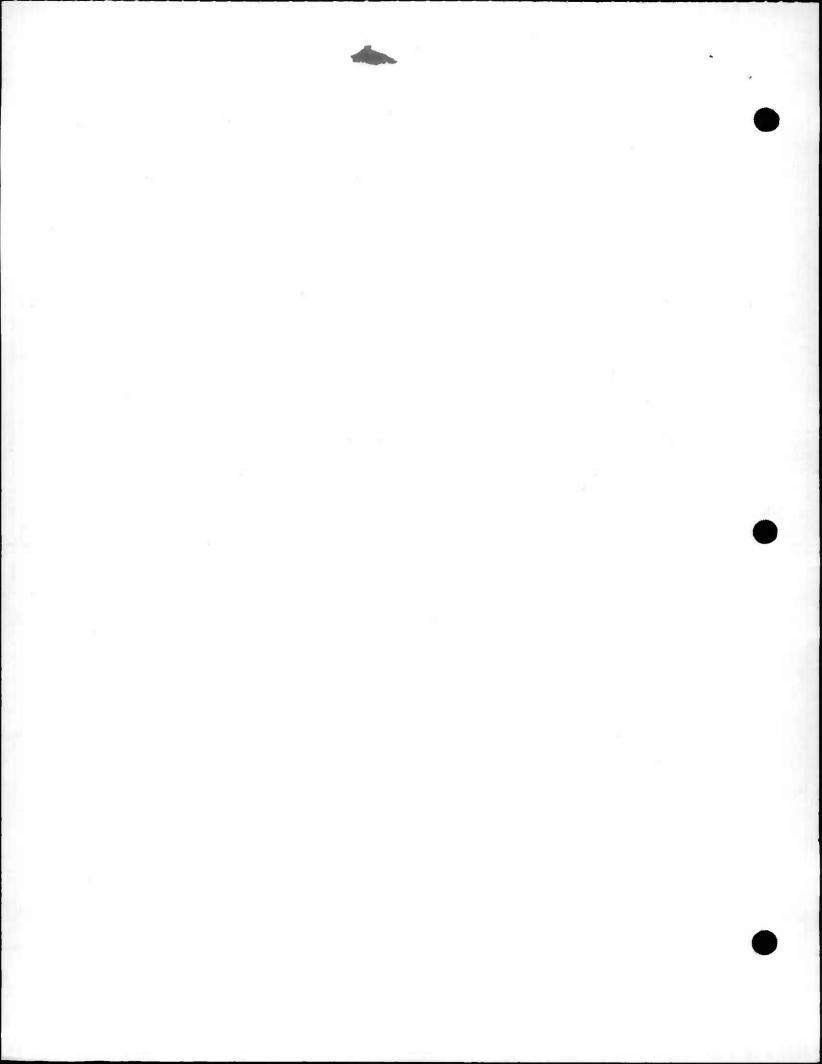
.

		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	ICATE (F HEALTH OF DEAT	AND MEN TH	TAL HYGIEN REG. NO.		231	4'
		1. DECEDENT'S NAME (First, Middle, Lest) WALTER	SAMUE	EL R	114	EV	M	ATE OF DEATH DATE OF DEATH DATE	1995	9:20	
		4. SOCIAL SECURITY NUMBER 217-36-9539	5. SEX 6. AGE ((In yrs. lest birthdey) 4 YRS.	IF UNDER 1 YE MONTHS DA	AR IF UNDER	24 MRS 7 D	ATE OF BIRTH		B. BIRTHPLACE (State (Country))	
3 should		9e. FACILITY NAME (If not institution, give s				WN OR LOCATI	ON OF DEATH	10,1		Y OF DEATH	
1, 2, 3	ТОЕ	HOLY CROSS HOSP	ITAL		SILV	ER SPR	ING		MON	TGOMERY	
permit. Pages	DIRECTOR	MARYLAND MONTG			Y, TOWN OR L			-		10d. INSIDE	
permit		10. STREET AND NUMBER	OTENT	1 0/1		101. ZIP COD	E		10g. CITIZ	1 TYES 2	-
ist.	FUNERAL	26050 WOODFIELD R					20872		UNI	TED STATE	:S
21215-0020 al or attending physician. for use as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 7 NO	It ye	DECENDENT Co. specify Cubs YES 2 NO	OF HISPANIC OR in, Mexicen, Pue Specify:	IGIN? (Specify Yes rto Ricen, atc.)	or No—	4. RACE — American Black, White, etc. Specify: WHIT	
21215 al or attend for use as	밀	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S (Give kind of	vork done durin	PATION g most of working	ng	16b. KIND OF BUS	INESS/INDU	STRY	
the hospital of detached for once.	COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +)	MAINTE				APARTME	NT HO	MES	
7 8 8 6 7	III	<u> </u>	AILEY			MAR	Y HAZEL	st, Middle, Meiden BLANKE	NSHIP		
be retained to 5 should be notified	은	19a. INFORMANT'S NAME (Type/Print) MARY BAILEY				TELD R		lumber, City or Town		MD. 20872	
5 may stor, pa		20e METHOD OF DISPOSITION 1 Buriet 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)		PLACE AND DATES				ATE 20c. LO	CATION — C	ty or Town, State	
Page ral direction		21. SIGNATURE OF FUNERAL SERVICE LIC		NOL GOST						MARYLAND E 20882	
BALTIN after death. Pag by the funeral dir moval. Icai examiner		· mariel 9	N. Bar	her	P.0.	BOX 50	38 LAY1	TONSVILL	E, MA	RYLAND	
within 24 hours upletely filled in cermation, or re-		23. PART I. Enter the diseases, or c shock, or heart fatture. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Coult	d the death. Do nach lins.	Stor C				ratory arre	Interva	ximats al Betwe and De
S, P.O. BOX 687 death certificate be executed ental Hygiene prior to burial, iry, or other traumatic e	RTIFIC	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c	CONSEQUENCE OF							
that the ned by the lith and M	4	PART II. Other significant condition	s contributing to death be	ut not resulting i	n ths under	iying cause g	given in Part i	24a. WAS AN PERFOR	MED?	24b. WERE AUTOPS AMAILABLE PR COMPLETION OF DEATH?	OF CAUSE
AL KEC e law requires has been sign Dept. of Hea		DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YE	S NO	☐ UNC	ERTAIN			1 TYES 2	□ NO
V: The I cate ha	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	OTHER:						
SICIAN SICIAN Certifi h the	PHYS	1 VES 2 NO 27. MANNER OF DEATH	1. Inpatient 2 ☐ ER/Output 28e. DATE OF INJURY	28b. TIM	E OF 28c	INJURY AT	sidence 6 🗆 0	ther (Specify) DESCRIBE HOW to	JURY OCCU	RED	
After this of death with	ВУ Р	1 Matural 5 Pending 2 Accident Investigation	(Month, Day, Year)			WORK?					
TTENDII TORI A after de 28 is		3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Speci	— At home, ferm, s	treet, tectory,	office	28t. L	OCATION (Street a lity or Town, State)	nd Number o	Rural Route Number,	
AL OR	APLET		CIAN: To the best of my knowle								
HOSPITAL FUNERAL Within 72	СОМР	2 MEDICAL EXAMINE	R: On the beele of examination	end/or investigation	n, in my opinio	on, death occur	ed at the time, d	ate end place, end	due to the	ceuse(e) end manner e	re stated.
TO THE HOSPIT TO THE FUNERA be filed within 7	BE C	296. SIGNATURE AND TITLE OF CENTIFIES	Kenkin	MB		DE DE	NSE NUMBER	4	29d. DATE :	SIGNED (Months Day, Ye	ier)
	10	30. NAME AND APDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	ATH (ITEM 27) (Type,	Print) 300	2 SH	DREK	HANRA	W	HAMMU!	15
		31. DATE FILED [MORE 97 1995	22 REGISTRAR'S SIGN	BURE arlall		- Spite	/	200.			

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

BEG NO.

	_	REGISTRAR		CERTIF	ICATE O	F DEATH	REG. NO		
		1. DECEDENT'S NAME (First, Middle, Last)	LIZABETH A.	BURNS			JULY 15	AY 1995 YEA	3. TIME OF OEATH M
P		4. SOCIAL SECURITY NUMBER 219-32-3625		(In yrs. last birthday) YRS.	IF UNDER 1 YEA MONTHS DAY		7. DATE OF BIRTH	8. Bif Co	THPLACE (State or Foreign units)
2, 3 should	TOR	9a. FACILITY NAME (# not institution, give s ATLANTIC GENERAL RESIDENCE OF DECEDENT	HOSPITAL		96. CITY, TOW BERL	N OR LOCATION OF DI	EATH	9c. COUNTY OF WORCE	F DEATH STER
permit. Pages 1.	DIRECTOR		ESTER	10c. CIT	BERLIN	CATION			10d. INSIDE CITY LIMITS? 1 YES 2 NO
is:	FUNERAL	100. STREET AND NUMBER 22 FAIRWAY LANE				101. ZIR CORE 21811			F WHAT COUNTRY? SA
ONE, MARYLAND ZIZIS-0020 6 may be retained by the hospital or attending physician. ctor, page 5 should be detached for use as the burial-transit nust be notified at once.	B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	If yes,	DECENDENT OF HISPAN specify Cuben, Mexica (ES 2 KNO Specify		Bi	ACE — American Indian, lack, Whita, alc. Decity: WHITE
NO 2121 hospital or atteached for use a	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		16a. DECEDENT'S (Give kind of v life Do NOT us HOMEM	USUAL OCCUP. work done during se retired.) IAKER	ATION most of working	OWN HON	SINESS/INDUSTRY	
d by the hospit d be detached d at once.	BE CO	17. FATHER'S NAME (First, Middle, Last) JOHN FELL					ME (First, Middle, Meiden RINE KUNZ	Surname)	
y be retained age 5 should be notified	5	19a. INFORMANT'S NAME (Type/Print) BERNARD BURNS		1344000	UCEAN	PINES	BERLIN, MI	n, State, Zio-Cada)	1
. Page 6 may b ral director, page		20e. METHOD OF DISPOSITION 1 Squriel 2 Cremation 3 Rem 4 Donetion 5 Other (Specify)	oval from State	PLACE AND DATE OF PLACE OF PLACE AND DATE OF PLA	EMOR I A	L PARK	7-18 BE	CATION — CITY OF	
death death fune		21. SIGNATURE OF PURENAL SERVICE LIC				RICH FUNER		BERLIN,	Mp., 21811
to be executed within 24 hours after sician and completely filled in by the prior to burial, cremation, or remova traumatic event, the medical	TION	iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate	a. DUE TO OR AS A	the death. Do rach line.	ual Fi:		h as cardiac or respi		Approximate interval Between Onset and Death
th certifical ending phy Il Hygiene I	ERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):				
in the said when	EDICAL C	PART ii. Other algnificant condition	a contributing to death b	ut not reaulting	in the underly	ring cause given in	Part i. 24e. WAS AN PERFOR		4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ath ath	MEDIC						1 YES 2	X NO	OF DEATH? 1 YES 2 NO
has loopi	AN:	DID TOBACCO USE CONTI		F DEATH YE			V 🗆		
ICIAN: The ertificate hithe State or item	YSICI	EXAMINER?	HOSPITAL:		OTHER:	lome 5 🗆 Rasidenca	6 Other (Specify)		
ATTENDING PHYSICIAN: The law ECTOR: After this certificate has b s after death with the State Dept.	ву рну	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)		M 1	INJURY AT WORK? YES 2 NO	28d. DEŞCRIBE HOW II	NJURY OCCURED	
OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate hours after death with the State Item 28 is marked, or Item	ETED	3 Suicide 6 Could not be 4 Homicide detarmined	26a. PLACE OF INJURY building, etc. (Spec	— Al home, ferm, a	itreet, factory, o	ffice	261. LOCATION (Street a City or Town, State)	ind Number or Run	al Route Number,
は 立た ==	COMPL		CIAN: To the best of my knowledge. R: On the basis of examination						e(a) and manner as stated.
TO THE HOSPI TO THE FUNER be filed within	BE	296. SIGNATURE AND TITLE OF CERTIFIER	7/>			b232	-	29d. DATE SIGN	ED (Month, Day, Year)
	2	30. NAME AND ADDRESS OF PERSON WHI	Z M.D	ATH (ITEM 27) (Type,	Tla	utic	Gren	Ho	S.C.
		31. DATE FILED (Month, Day, Year) JUL 1 7 1995	32. DEGISTRAR'S SIGN						



CERTIFICATE OF DEATH

1 - STATE REGISTRAR

95 23149

1995

9c. COUNTY OF DEATH

St. Marys

USA

St. Inigoes, MD

10g. CITIZEN OF WHAT COUNTRY?

09.

1913

3. TIME OF DEATH

10d. INSIDE CITY LIMITS?

14. RACE - American Indian, Black, White, stc.

Specify: Black

1 TES 2 X NO

interval Batween

Onset and Death

co, wute

24b. WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 TES 2 NO

29d. DATE SIGNED (Month, Day, Year)

6. BIRTHPLACE (State or Foreign Country)

Maryland

11:33pm

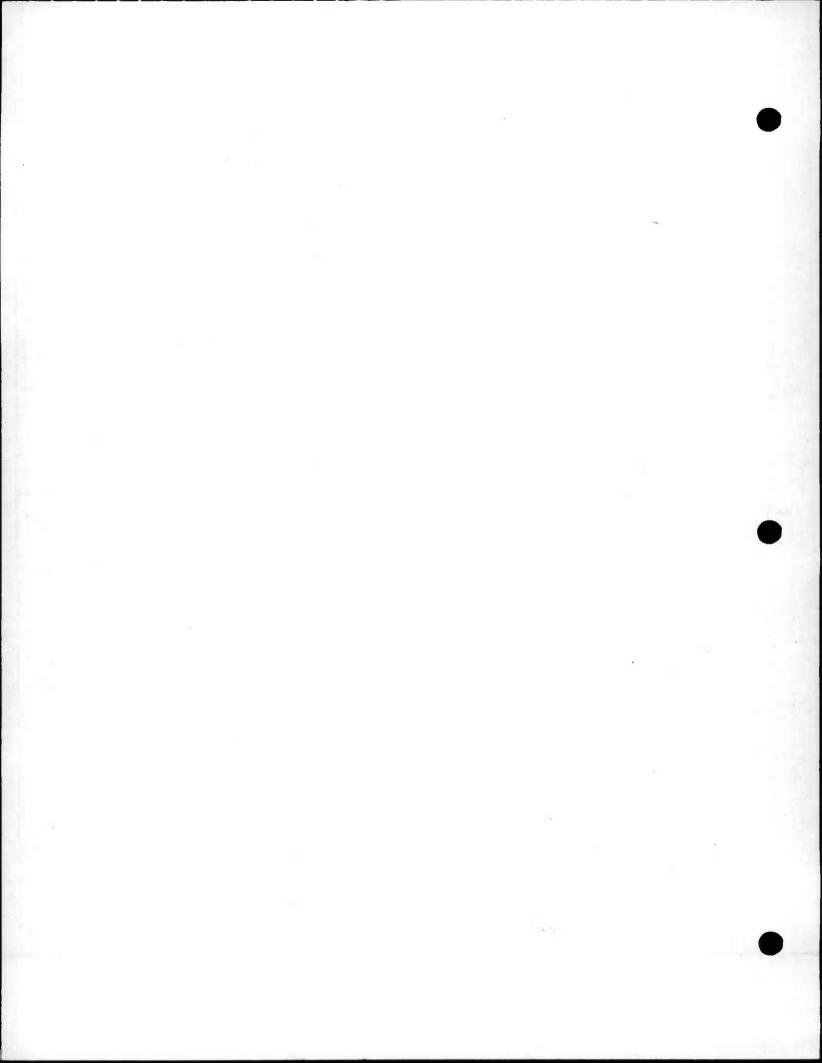
1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH John Lewis Ball, Jr. July A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) DAYS HOURS 1 X M 2 - F 82 204-07-9086 YRS. June 12. 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Patuxent Naval Hospital Lexington Park RESIDENCE OF DECEDENT Pages 1 10c. CITY, TOWN OR LOCATION Maryland St. Marys St. Inigoes permit. 10e. STREET AND NUMBER Zion FUNERAL 10f. ZIP CODE Mt. Zoin Church Rd. funeral director, page 5 should be detached for use as the burial-transit 20684 Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puarto Rican, etc.) BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married 1 YES 2 NO Specify: ВУ 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 12 Laborer Construction 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) notified at John Lewis Ball, Sr. Nettie Washington BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 10904 Woodlawn Blvd. Nettie E. Ball Largo, MD 20772 20a. METHOD OF DISPOSITION þ 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, Stata 1X Burial 2 Cremation 3 Ramoval from State
4 Donation 5 Other (Specify) must Zion UM Church Cem. 7/15/95 22. NAME AND ADDRESS OF FACILITY Sewell Funeral Home examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE rell spencer 1451 Dares Beach Rd. Prince Frederick, MD attending physician and completely filled in by the Intal Hygiene prior to burial, cremation, or removal. medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or haart fallura. List only one cause on each line **IMMEDIATE CAUSE (Final** the disease or condition ____ andiro orrest event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequantially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 10 signed by the atten Health and Mental H PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? Obstacke pulmong Disege shows any 1 TES 2 NO ţ, DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h EXAMINER? HOSPITAL: OTHER: DR ATTENDING PHYSICIAN: 1 TYES 2 NO 1 Inpatient 2 ER/Outpatient 3 I DOA 4 - Nursing Home 5 - Rasidence 8 - Other (Specify) of the 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED marked. 1 Netural 5 Pending 1 YES 2 NO BY death Investigation After 2 Accident 26a. PLACE OF INJURY — At home, farm, streat, factory, offica building, atc. (Specify) 3 Suicida 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .09 COMPLETED 6 Could not be DIRECTOR: / after 28 i 4 Homicide datarmined item 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL D
TO THE FUNERAL DI
BE filed within 72 ho
IMPORTANT: If ite 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE CM 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, CATALANT ASSOCIATION OF THE PLOT BOX 654

Leonardtown, MD 20650 JUL 1 4 1995 Juli Davidson Rardall

DHMH-16 Ray 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEAL DIRECTOR: After this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State begin or Health and Mental Hygiene prior to removal. The medical examiner must be nettited at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		MENT OF HE		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	Harry Mauric	e Boyer					1995	9:10 A M
	4. SOCIAL SECURITY NUMBER		In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	a. Bi	RTHPLACE (State or Foreign buntry)
	215-36-6981 9a. FACILITY NAME (If not institution, give:	1 K M 2 □ F	87 YRS.			Sept 28,	1907	Maryland
Œ				9b. CITY, TOWN OR		EATH	9c. COUNTY C	
DIRECTOR	Frederick Memori	al Hospital		Frederi	ck		Frede	rick
E E	10e. STATE 10b. COUNT	Y	10c. CITY	TOWN OR LOCATIO	ON			10d, INSIDE CITY LIMITS?
	Maryland Carr	011	Uni	on Bridg				1 X YES 2 NO
FUNERAL					ZIP CODE			OF WHAT COUNTRY?
I N	30 South Main St	12. WAS DECEDENT EVER IN	U.S. ARMED		1791	NIC ORIGIN? (Specify Yes	USA	105
	1 Never Merried 2 Merried	FORCES? 1 YES	2 NO	If yes, spec	offy Cuben, Mexice	n, Puerto Ricen, etc.)	8	ACE — American Indian, liack, White, etc. pecify:
D BY	3 Widowed 4 Divorced	IL CONTRACTOR SECURITION						White
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	completed)	(Give kind of we life. Do NOT use	JSUAL OCCUPATION ork done during most	of working	16b. KIND OF BU	SINESS/INDUSTR	Υ
1 2	Elementary/Secondary (0-12)	College (1-4 or 5+)	self	retired.)		farming		
OM	17. FATHER'S NAME (First, Middle, Last)		ocii		18, MOTHER'S NA	ME (First, Middle, Maiden	Surneme)	
BE C	Willis Boyer				Laura H			:
년 8	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street and	d Number or Rural i	Route Number, City or Tow	n, State, Zip Code,)
-	Sylvia L. Burrie:	r	10543	Green Va	lley Rd.	, Union B		
	20e. METHOD OF DISPOSITION 1 X Burlet 2 Cremetion 3 Rem	oval from State cem	PLACE AND DATE OF	er place)		70/16 20c. LO		the same of the sa
	4 □ Donetion 5 □ Other (Specify) 21. SIGNATURE OF FUNERAL BERVICE LI	CENSEE /	nion Cha	pel Ceme	tery	1995 Libe	ertytown	n, Maryland
	Pun VI	1/200	0.					ck, MD 21702
-	23 PART I FOR the discourse of	, KMGE						CR, 11D 21702
		List only one cause on as	ich lina.	ot antar tha mode	a of dying, auc	h aa cardiac or respi	ratory arreat,	Approximata intarvai Between
	IMMEDIATE CAUSE (Final disease or condition	PNEUM	DNIA					Onset and Daath
1	resulting in death)		CONSEQUENCE OF	:				1 Day
Z	The state of the s	· SEPS	15.					1 Day
15	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF)	:				
	cause. Entar UNDERLYING CAUSE (Disease or injury	CDUE TO (OR AS A	CONSEQUENCE OF					
CERTIFICATION	that initiated events resulting in death) LAST		OUNSECOLUTION OF					
	DART II Other desilies at a sellie	a						
CAL	PART II. Other significant condition	a contributing to death be	ut not resuiting in	tha undarlying	cause given in	Part i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC	11170ca vice -					1 _ YES 2	NO	OF DEATH?
Σ	DID TOBACCO USE CONT	PIRLITE TO CAUSE O	E DEATH VEG	ПОП	LINICEDTAIN		- 1	1 TYES 2 THO
AN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		UNCERIAII	107		
Sic	1 TYES 2 DATE	HOSPITAL:	etlent 3 DOA	OTHER:	5 Residence	8 Other (Specify)		
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c, INJUI		28d. DESCRIBE HOW II	NJURY OCCURED	,
BY	1 Natural 5 Pending 2 Accident Investigation			M 1 TYE				
	3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF INJURY building, etc. (Speci	— At home, ferm, sti	reet, tactory, office		28t. LOCATION (Street & City or Town, State)	and Number or Rur	ral Route Number,
COMPLETED	29e. CERTIFIER	ALCOHOLOGICAL CONTRACTOR						
MP		ICIAN: To the best of my knowle ER: On the beele of examination						
	29b. SIGNATURE AND TITLE OF CERTIFIE							
BE	02-7				29c. LICENSE NUN			NED (Month, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEA						
	SAEEN ZAID		TOLL	HOUSE	AVE,	FRED	BRICK	- Mn
	31. DATE FILED (Month, Day, Year).	32. REGISTRAR'S SIGNA	TURE Vardal	61				
		-						



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF	DEATN			3. TIME OF DEATN
	,	Wi	llie	Bris	ster					July	12	199	SYEAR	3:00 P M
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. less		IF UNDER	1 YEAR	IF UNDER	R 24 HRS.	7 DATE OF	BIDTH		_	HPLACE (State or Foreign
	255-14-200	Ĺ	1 M 2 F	78	YRS.	MONTHS	DAYS	HOURS	MIN.	Mar.	10.19	917	Count	th Carolina
	9a. FACILITY NAME (If not in					9b. CITY	, TOWN	OR LOCATE	ON OF DE				NTY OF E	
9	Particular and the second of t		en Rd.			F	red	ericl				F	rede	rick
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY			40. 00			www						
<u> </u>	Maryland		derick		10c. CIT	Y, TOWN (in the second					10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER		MOTTCK					erici						1 X YES 2 NO
¥			Den Rd.				"		701			10g. CIT	US	WHAT COUNTRY?
FUNERAL	11. MARITAL STATUS		_	THEVER IN U.S. ARI	MED	13.	WAS DEC			VIC ORIGIN?	Specify Vee	or No.		E — American Indian,
	1 Never Married 2	1 2 2 2 2 2 2	FORCES? 1	YES 2 N	0		If yes, sp		ın, Mexice	n, Puerto Ric		Or 140-	Blac	k, White, atc.
BY	3 Widowed 4 Divo	rced		3-1963				24 110	Specif	γ.			B	Lack
COMPLETED	15. DEC (Specify ont	EDENT'S EDUC y highest grade	CATION completed)	16a. DE(CEDENT'S	USUAL O	CCUPATIO	DN ost of working	na	16b, K	IND OF BUS	INESS/INI	DUSTRY	
	Elementary/Secondary (0		College (1-4 or 5	+) life.	-	-		st of working		77		m4-4	h (- 12
MP	17. FATNER'S NAME (First, M				Band	iman	re	tire			ited		res 1	THEY
			and the second					16. MOT		ME (First, Mid				
BE	19a. INFORMANT'S NAME (7	Dave Br	13 CEF	404	MAN INC	100050				a Will				
2		Briste	r	190	2490	Bear	De:	n Rd	or Aural I	Route Number, rederi	ck, I	i, State, Zij	21701	
	20a. METHOD OF DISPOSIT		oval from State	20b. PLACE A	ND DATE	OF DISPOS	ITION (Na	ime of	7/1	5/95TE	20c. LO	CATION —	Cify or To	own, State
	4 Donation 5 D Other		17-29	Montgo	mer	Cre	ema t	oriw	n, Inc	0.	Be	thes	da,	Md.
	21. SIGNATURE OF FUNERA	L SERVICE LICI	ENSEE	/		22.	NAME AND	L I	SS OF FA	SWOTT	. P.			
	Cllin	IN	Noles	wath	>	2	2640	l Ric	dge I	Rd. I	amaso	us.	Md.	20872
	23. PART i, Enter the di	isesses, Dr C	omplications the	t ceused the dec	eth. Dp r	Dt enter	the mo	de Df dy	ing, suc	h es cerdie	c or respir	atory sn	reet,	Approximate
	IMMEDIATE CAUSE (FIR		list only Dne cat		-									interval Between Onset and Deeth
-	diseese or condition resulting in death)	+ .	Metas	STATIC	- 17	05	ПАТ	-5-	(,	ANCS	- R			14 years
-			DUE TO	(OR AS A CONSEC	UENCE O	F):								10303
8	Sequentially list conditi	inna b												
MEDICAL CERTIFICATION	if any, leading to immed csuse. Enter UNDERLY	diate	DUE TO	(OR AS A CONSEO	UENCE O	F):								
윤	CAUSE (Diseese or inju- thet initisted events		DUE TO	(OR AS A CONSEO	UENCE OF	F):								
E	resulting in death) LAS	т .				,								i
S														
¥	PART ii. Other significe	nt conditions	contributing to	desth but not re	euiting	n the un	derlying	g ceuse g	given in	Part i. 24	Ia. WAS AN A		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă										_ 1	TYES 2	NO		COMPLETION OF CAUSE OF DEATH?
							1	, _						1 - YES 2 - NO
ä	DID TOBACCO U		IBUTE TO CA				-	UNC	ERTAIN	1 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	D MEDICAL	HOSPITAL:			OTHER		1		_				
ΥS	1 TYES 2 NO			ER/Outpatient 3		4 🗆 Nun	Ing Nom	\rightarrow	eldence	6 Other (S				
	_	Pending	28a. DATE OF (Month, D		28b. TIM INJ	URY	_	RK?		26d. DESCR	IBE NOW IN	JURY OC	CURED	
B	2 Accident 3 Suicide	investigation	26a PLACE O	F INJURY — At hon	no form o		1 🗆 1		NO	****				
COMPLETED		Could not be determined	building,	etc. (Specify)	na, tatin, t	Hreet, ract	ory, omic	•		City or	ON (Street a) fown, State)	nd Number	or Rural F	Route Number,
الإ	29a. CERTIFIER 1 CERT	IFYING PHYSIC	CIAN: To the beat of	my knowledge des	th occurre	od at the ti	me dete	and place	and due	to the sauce	(a) and man			
ž I	(Check only one) 2 MEDI	CAL EXAMINER	t: On the beats of a	remination end/or in	rveatigatio	n, in my o	pinion, d	eath occur	ed at the	time, date en	(s) and <i>m</i> ani d place, end	due to th	e causele) end manner as stated.
	29b. SIGNATURE AND TITLE								NSE NUM		1			
H	nanus 1		21110	a. MD)			-		580				(Month, Day, Year)
유	30. NAME AND ADDRESS OF	PERSON WHD	COMPLETED CAUS		7	Print)		D.	5 1		9	▶ J.	ny	10,1110
	Nancy A. Day			•			ledi.	cal (Cent	er.Was	hiho	ton.	D.C. 2	20307-5001
		Wheel	20 DECICEDA										7 - 1 -	
	JUL .	17 199	0 0	R'S SIGNATURE	Markle	41								Ì

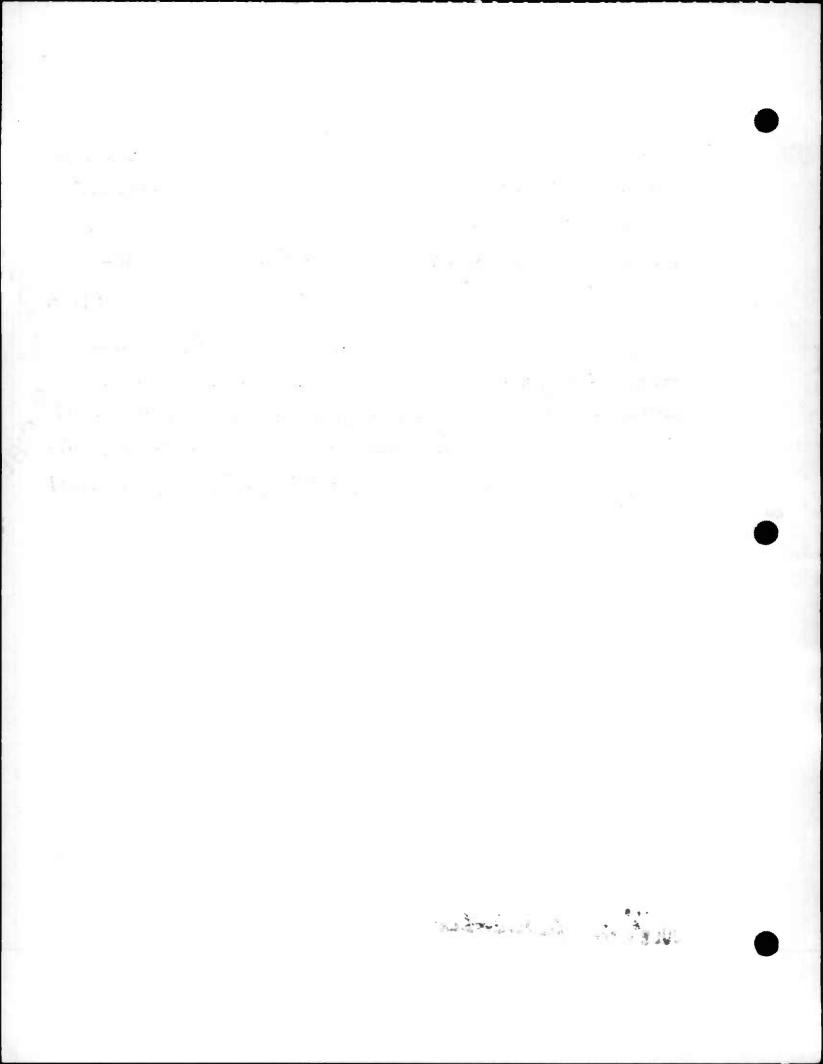
- ... Various tradition of the contract of the

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitied at once.

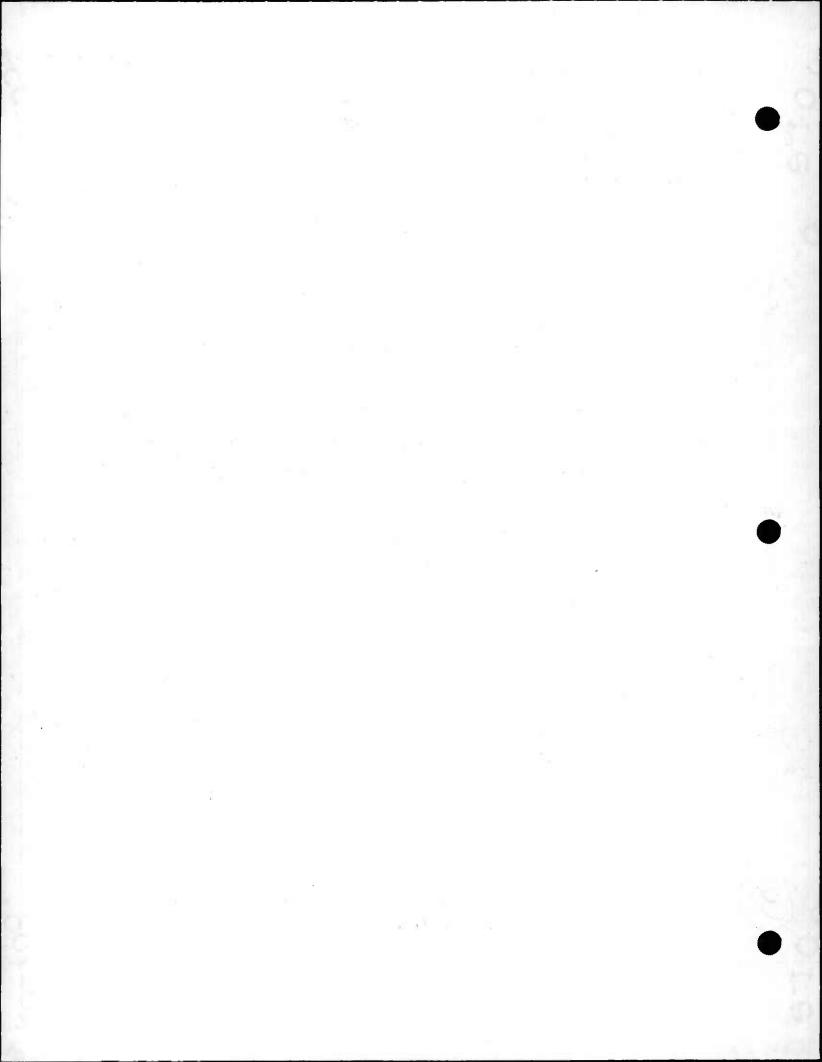
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /		T OF HEALTH AND	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)	4 1			2. DATE OF DEATH MONTH D	AY YEAR	3. TIME OF DEATH
	Hrthur Bro				07 1-	7 95	m 6080
		5. SEX 6. AGE (In yrs. las	YRS. IF UND MONTHS	ER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIFTTH (Month, Day, Year) 05 -(0-2)	Cour	HPLACE (State or Foreign http://
œ	9a. FACILITY NAME (If not institution, give street	et and number)	9b. CI	Y, TOWN OR LOCATION OF D	EATH	9c. COUNTY OF	DEATH
DIRECTOR	RESIDENCE OF DECEDENT	NICK		HIMOIC		BAH	MOIE
IRE(10a. STATE 10b. COUNTY		10c. CITY, TOWN	OR LOCATION			10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	nelSc4	Cris.	101, ZIP CODE		Lan Citizen of	1 YES 2 NO
FUNERAL	1 SOMERSEL DI	VE Apt 10		21817		U.	S.
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. AF	AMED 13	WAS DECENDENT OF HISPAI It yes, specify Cuban, Maxico			CE — American Indian, ck, White, atc.
BY I	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 TES 2 NO Specifi			em Black
	15. DECEDENT'S EDUCA (Specify only highest grade co		ECEDENT'S USUAL	OCCUPATION of during most of working	16b. KIND OF BU	SINESS/INDUSTRY	placit
COMPLETED			Do NOT use retired)	1		
DMP	17 FATHER'S NAME (First, Middle, Lest)	<u> </u>	aboli		ME (First, Middle, Maiden	WC742	
BE C	Arthul Brouch	ton		Bess	CE BYO!	1	`
TO B	19a, INFORMANT'S NAME (Type/Prigt)	19	b. MAILING ADDRE	SS (Street and Number or Rural		rn, Plate, Zip Code)	
-	- 10111	MU I	OG MAL	JAND AVE	Cristica	1, 40.	21811
	20a. METHOD OF DISPOSITION 1		AND DATE OF DISPO ematory or other place ANS LEGY		724/45	CATION - City or 1	own, State
	21. SIGNATURE OF FURTHAL SERVICE-LICES			. NAME AND ADDRESS OF FA	CILITY	1 1 L	n Mes.
	Hullen E.	Man		Anthony E.L	NAID THO	etal to	71817
	23. PART i. Enter the diseases, or con	mplicetions that coused the de	eeth. Do not ente	or the mode of dying, suc	h as cardiac or resp	ratory arrest,	Approximata
	IMMEDIATE CAUSE (Finel	st only one cause on each line	в.				Intervei Between Onset end Deeth
	disease or condition resulting in death) e.	Metastatic DUE TO (OR AS A CONSE	Canc	20			
_		DUE TO (OR AS A CONSE	OUENCE OF):				
2	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSE	OUENCE OF):				
CERTIFICATION	CAUSE (Disease or injury	DUE TO (OD 40 4 COVER					
RTIF	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSE	OUENCE OF):				
	DAST it Other significant conditions						
CAL	PART ii. Other significent conditions	contributing to death but not i	resulting in the t	inderlying cause given in	PERFOR	MED?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDI					1 🗆 YES 2	N NO	OF DEATH?
ž	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF DEA	TH YES	NO UNCERTAIL	N 🗆		1 123 2 110
CA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		CE OF DEATH (Chec				
₹ 1	1 YES 2 KNO 1	OSPITAL: Supplement 2 ER/Outpetlent 3 28a. DATE OF INJURY	28b. TIME OF	rsing Home 5 - Realdence		HIDY OCCUPED	
	1 Natural 5 ☐ Pending	(Month, Day, Year)	INJURY	WORK?	28d. DEŞCRIBE HOW I	NJURY OCCURED	
D BY	3 Suicide 8 Could not be	28a. PLACE OF INJURY — At he building, etc. (Specify)	ome, tarm, street, ta	ctory, office	28f. LOCATION (Street of City or Town, State)	and Number or Rural	Route Number,
	4 Homicide determined	0.2501/0.251/0.007/			Only or lown, oresey		
COMPLETE		AN: To the best of my knowledge, de					
00	Z MEDICAL EXAMINER:	On the beals of exemination and/or	Investigation, in my			d due to the cause	a) and manner as stated.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	MA		29c. LICENSE NUI	MBER	29d. DATE SIGNE	D (Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (ITE	M 27) (Type, Print)	MKOT	X	1117	17)
	A.A.	Greene St Ba		21202			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAS SIGNATURE					
	JUL 2 0 1995 gola						



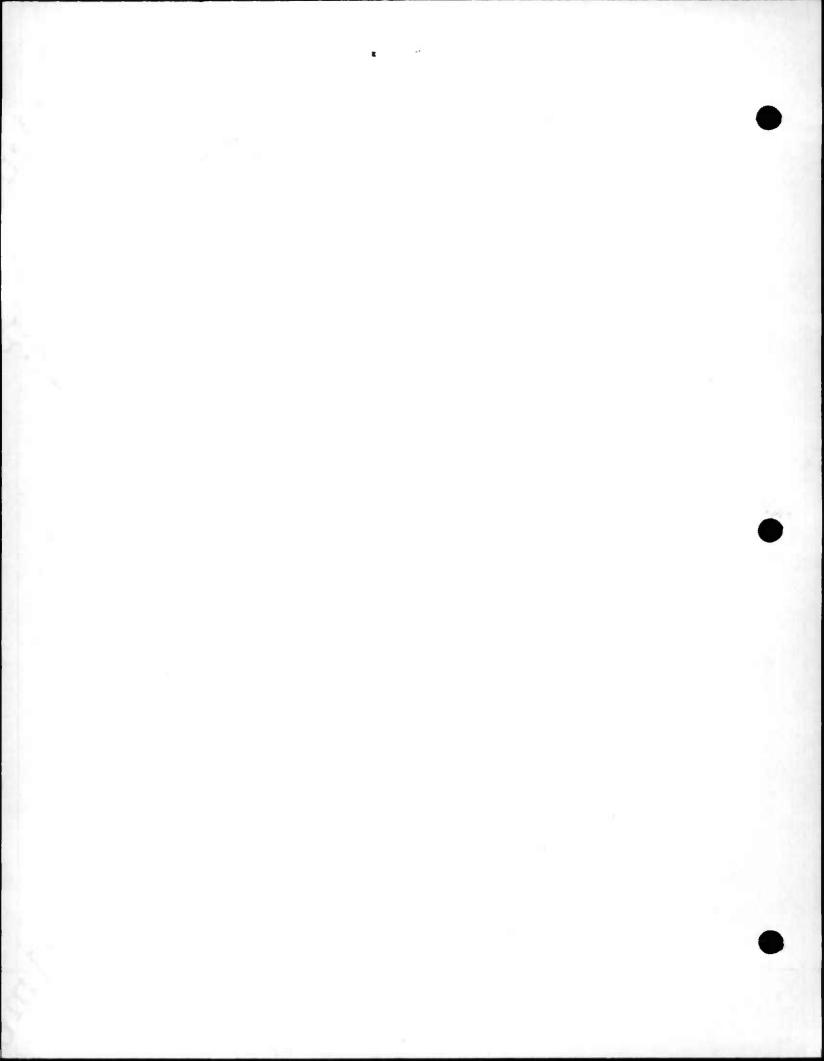
1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH
REG. NO.

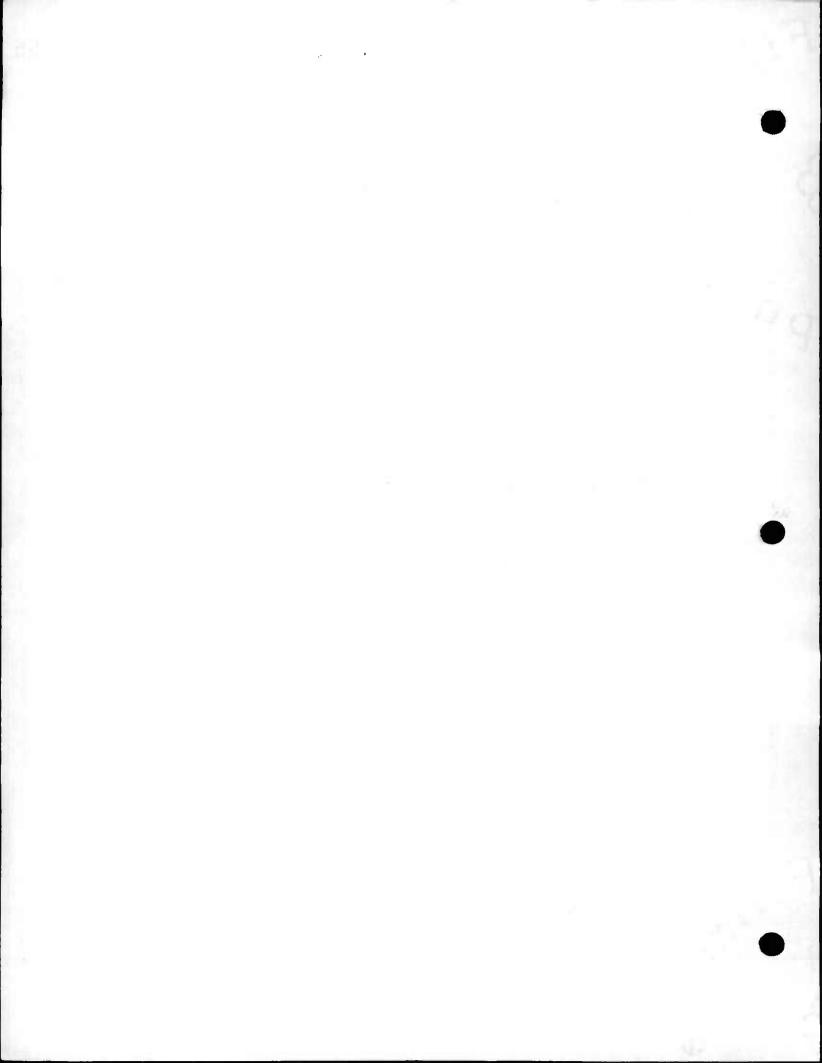
		REGISTRAN		CENTIFIC	CATE	JF DEATH	REG. NO		
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3. TIME OF DEATH
		CHARLES	3		MIA		July 1	8 19 E	5:45 a M
		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH		
					MONTHS DA		(Month, Day, Year)	8. 6	BIRTNPLACE (State or Foreign Country)
골		461-01-5013	¹\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1 THS.			5-15-14	l J	EXAS
3 should		9a. FACILITY NAME (If not institution, give str	eet end number)	- 7 - 0 - 11	96. CITY, TOV	WN OR LOCATION OF DE	ATH	9c. COUNTY	OF DEATN
	DIRECTOR	Southern Maryla	and Hospit	ai cenqe	er	Clinton		Prince	e Georges
1, 2,	1 5 1	RESIDENCE OF DECEDENT						1	, cccracs
	ΙŭΙ	10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LO	CATION			10d. INSIDE CITY
2	1 5 1	MD		T 7 7777	Dr				LIMITS?
permit. Pages		10e. STREET AND NUMBER		LAUR	EL				TYPES 2 NO
	8					10f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
020 physician. burial-transit	FUNERAL	8749 CONTEE RO	AD			20708		U.S	S.A.
215-0020 attending physician se as the burial-tra	5	11. MARITAL STATUS	12. WAS DECEDENT EVER		13. WAS	DECENDENT OF HISPAN	IIC ORIGIN? (Specify Yes		RACE — American Indian
9 PF PF		1 Never Merried 2 Merried	FORCES? 1 TYPES	2 NO	If yes	i, specify Cuben, Mexice	n, Puerto Rican, etc.)		Black, White, etc.
aling the	面	3 ☐ Widowed 4 🏋 ∭Volvorced			1	YES 2 NO Specif	ζ.		Specify: BLACK
15 tend	ا ۾ ا	15. DECEDENT'S EDUC	ATION	18a. DECEDENT'S U	ISUAL OCCUE	MICH	16b. KIND OF BUS		
0r a 0r a		(Specify only highest grade of		(Give kind of wo	ork done during	most of working	100. KIND OF BUS	NINE 33/INDUST	HT
d fo	ا يّا ا	Elementary/Secondary (0-12)	College (1-4 or 5+)				SCHOO)L	
She she	Σ		4yrs	TEAC	HER				
YLAND 2 by the hospital be detached to at once.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)	
M Pe		JOHN MARSHALL	CAIN			A ATATA ME	AT CITACE		
NR ned ould	BE	19e. INFORMANT'S NAME (Type/Print)	CATIV.	19h MAII ING A	nnasee /co	AININA MU	AE SHACKE	TEORD	
MARYLAND 212: 9 retained by the hospital or att 15 should be detached for use notified at once.	임								
y be		CHERYL CAIN		1201	gwate	rside vi	ew DR.Re	ston	VA22094
BALTIMORE, MARYLAND 21215-0020 er death. Page 6 may be retained by the hospital or attending physic the funeral director, page 5 should be detached for use as the burial val.	1 1	20e. METHOD OF DISPOSITION 1) Burlai 2 Cremation 3 Remove		b. PLACE AND DATE OF		(Name of	DATE 20c. LO	CATION - City	or Town, State
MOR e 6 may rector, p		4 Donation 5 Other (Specify)		metery, crematory or othe OUANTI	CO NA	TL.	7721 0	UANTI	CO VA.
ALTIM death. Page e funeral dire I.		21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE			E AND ADDRESS OF FA	CILITY		
ath.		10		7	THE	HOUSE O	F WILLIA	MS	
BA the fet de the fet fet fet fet fet fet fet fet fet fe		James E.	Villu.	nes		1 14th S			
C 3 af		23. PART i. Enter the diseases, Dr co	mplications that cause	d the death. Do no	t enter tha	mode of dving, suc	h as cardiac or resol	retury arrest	Approximate
Mours of in the		snock, or neart failure. L	ist only one cause on	each line.				ioloty altoot,	interval Between
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		iMMEDIATE CAUSE (Final disease or condition	1)-/-	- / /					Onset and Death
within 24 In pletely fille cremation, vent, the		resulting in death)	Hen	Valrata	m				Fole
60 with			DUE TO JOH AS	A CONSEQUENCE OF	1)				
68760 ecuted wit and comple burial, cre atic even	z		1724	our	0				Idan
	CERTIFICATION	Sequentially list conditions,	DUE TO OR AS	A CONSEQUENCE OF):		, ,			1000
O. BOX ertificate be er ing physician a rgiene prior to other traum	₹	if any, leading to immediate cause. Enter UNDERLYING	Calina	Care	1/	1 din	refo	· 1 ·	2 / 12
certificate ding physical hygiene pri	유	CAUSE (Disease or injury C.	DUE TO (OR AS	A CONSEQUENCE OF:	mon	5 WWY	V 1 ceto	2100	16/11
O. B ertificate ing phys rgiene p	Ē	that initiated events resulting in deeth) LAST	DUE TO (OH AS	A CONSEQUENCE OF):		V			
O # B # P	6	d.							
ORDS, F that the death ed by the atter th and Mental any injury, o		DART II Other circlificant conditions	annething a last						
ORDS, that the de- ed by the at th and Ment any injury.	MEDICAL	PART ii. Other significant conditions	continuuting to deeth	out not resulting in	the underl	ying cause given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
that the and any	용매						1 YES 2	A 4	COMPLETION OF CAUSE
LECO luires the signed Health a	ш						_	A	OF DEATH?
- 5 5 5 E		DID TORACCO HEE CONTR	IDLITE TO CALLES A	NE DEATH VEC	Пио				1 YES 2 NO
See se	SICIAN:	DID TOBACCO USE CONTR	IBUIL IO CAUSE (4 L	- FE 161	
VITA NN: The ficate h State [ㅎ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSFITAL:	26. PLACE OF DEATN		ne)			
MAN: Triffica he St.	S	1 TYES 2 TO NO	1 D Inpatient 2 ER/Out		OTHER:	fome 5 - Residence	8 Other (Specify)		
1 S S D	PHY	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME		INJURY AT	28d. DESCRIBE HOW II	JURY OCCURE	D
NG PHYS fler this ceath with marked,	- 10	Natural 5 Pending	(Month, Day, Year)	INJUF	PY .	WORK?		ioon, oooong	
After death	B	2 Accident Investigation				YES 2 NO			
	0	3 Suicide 8 Could not be	28e. PLACE OF INJUR' building, atc. (Spe	f — At home, ferm, strendingly)	eet, factory, o	rifica	28f. LOCATION (Street a City or Town, State)	nd Number or Ri	ural Route Number,
OR ATTEN OR ATTEN DIRECTOR: hours after		4 Homicide determined							
OR A DIRECTOR A Hours	ا ت	29a. CERTIFIER 1 CERTIFYING PAYERS	AN: To the heat of our trans	1.4. 4.4					
보 국 가 ==	COMPLET	(Check only one) 1 CERTIFYING PNYSICI							
2 E E	Ņ.	2 MEDICAL EXAMINER	On the basis of axamination	on end/or investigation,	In my opinio	n, death occured at the	time, data end place, en	due to the ceu	use(e) end menner as stated.
TO THE HOSPITAL TO THE FUNERAL DE NIED WITHIN 72 IMPORTANT. II	<u></u>	296. SCHATURE OND TITLE OF CERTIFIER	0 . /	7	140	294: LICENSE NUM	BER	29d. DATE SIG	NED (Month, Day, Year)
五五五 8	m	Ma Dan	12 11	1 /	Plan	1.5	11435	D 177	Th/ 100
- F 2 =	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF T	//	Con the	CAN D ~	7777	- 1 /	J-1773
2)				_).			THE RESERVE OF THE
7/		L. BERWA, MI		CIUD BK	BAICH	Y AVE,	CLINTON	V m	D 20735
//		31. DATE FILED (Month, Day, Year)	32. REGISTRANS SIGN	ATURE PL					
		JUL 20 1995	Jun a wa						



		FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF I	HEALTH AND	MENTAL HYGIE		
	į.	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
		Mary Anna Eliza					July	15, 1995	10:16 am
	9	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIP Cor	THPLACE (State or Foreign intry)
ploods		216-14-9196 9a. FACILITY NAME (If not institution, give s	1 M 2 F	79 YRS.	AL OUTY TOWN	201000000000000000000000000000000000000	July 4, 1		ryland
1, 2, 3 sh	DIRECTOR	Kent and Queen A		al	Chester	town MD	EATH	sc. county of Kent	DEATH
Pages	REC	10a. STATE 10b. COUNT	Υ	10c. CIT	Y, TOWN OR LOCAT	TION			10d. INSIDE CITY LIMITS?
permit. F		Maryland Ker	ıt	Che	stertown				1 TES 2 NO
	FUNERAL	22432 Cross Road	ı		101	I. ZIP CODE			F WHAT COUNTRY?
020 physician. burlal-transit	S	11. MARITAL STATUS	12. WAS DECEDENT EVER II	N U.S. ARMED	13. WAS DEC	21620	NIC ORIGIN? (Specify Y	USA	CE Amadaan tadaa
21215-0020 al or attending physician, for use as the burial-tran	B	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 TYES	2 X NO	If yes, sp	ecity Cuben, Mexico 2 X NO Specif	en, Puerto Ricen, etc.)	Bio	CE — Americen Indian, ack, White, atc.
r aften use as	ETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S	USUAL OCCUPATION	ON of working	16b. KIND OF B	USINESS/INDUSTRY	
	9	Elementary/Secondary (0-12)	College (1-4 or 5+)		work done during mo se retired.)				
AND the hosp detached	COMPL	12th 17. FATHER'S NAME (First, Middle, Last)		Domest	ic Engir	1	Domes		
YLA by the		John T. Richards	0.7				ME (First, Middle, Maide		
MARYLAND 2- retained by the hospital o 5 should be detached for notified at once,	BE	19e. INFORMANT'S NAME (Type/Print)	.011	19b, MAILING	ADDRESS (Street e		anna Cotto Route Number, City or To		
	2	Barbara Wilson					Chesterto		21620
BALTIMORE, ter death. Page 6 may be the funeral director, page wal.		20e. METHOD OF DISPOSITION Surfel 2 Cremetion 3 Rem	oval from State 20b	PLACE AND DATE	OF DISPOSITION (Na	ame of	DATE 20c. L	OCATION — City or	
direct direct		4 Donetion 5 Other (Specify)		Asbury U		rch Cem.	7-20-95	George	town, Md.
uneral					Ben Ben	nie Smit	ch Funeral	Service	s
BA Is after de n by the fi removal.	_	1/100			P.C	Box 16	87, Easto	n, Md. 2	1601
within 24 hours within 24 hours npietely filled in cremation, or re		23. PART I. Enter the diseases, or a shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Carline	the death. Do rench line.	Man	- Si	ndelen.	death	Approximate interval Between Onset and Daath
P.O. BOX 68' h certificate be execute inding physician and ci Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):	LOVALL	lar di	Ilazı.	years
이 의 물 호 름	AL C	PART II. Other significant condition	s contributing to death b	ut not resulting I	in the Underlying	cause given in	Part I. 24a. WAS AI	N AUTOPSY 2	Ib. WERE AUTOPSY FINDINGS
RECORI requires that it been signed by of Health and shows any in	MEDIC/						PERFO	PRMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AL RE s law req has been Dept. of 23 sho		DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YE	S NO	UNCERTAIN	v 🗆		1 TES 2 NO
# # # # # #	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	TH (Check only one) OTHER:	6.4			
CENTIFICAN The S	PHYS	1 YES 2 NO	1 Inpatient 2 ER/Outp	_	4 - Nursing Home		8 Other (Specify)		
NG PHYSIC frer this ce eath with th	BY PI	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIMI	URY WO	URY AT RK? 'ES 2 \(\) NO	28d. DEŞCRIBE HOW	INJURY OCCURED	
TTENDI TTENDI TTOR: A after d	- 11	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, a	street, fectory, office		281. LOCATION (Street City or Town, State	end Number or Rure i)	Route Number,
	PE I	29e. CERTIFIER (Check only	CIAN: To the best of my knowl	edge, death occurre	ed at the time, date	end place, end due	to the cause(e) end ma	nner se stated.	
THE HOSPITAL THE FUNERAL filed within 72 i	COMPLETED	one) 2 MEDICAL EXAMINE	R: On the besie of examination						(s) end manner es stated.
물 물을 통	띪	29s. SIGNATURE AND TITLE OF DESCRIPTIONES	2	15		29c. LICENSE NUN	BER 105	29d. DATE SIGNE	D (Menth, Day, Year)
₹ \$99	2	30. HAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print) 1	7167	80	1-1/1	0/75
		Wayne DU)	enliamin	M.D.	Che	17-TO	an M	1 216	20
		31. DATE FILED (Month, Day, Xear) JUL 21 1995	32. REGISTRAR'S SIGNA	Andall.	1			1	
		UUL 61 1333	The same of						



		1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF		MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Less MILDRED CECELIA	•				2. DATE OF DEATH DOUBLE DOUBLE DOUBLE DEATH DOUBLE DEATH DEA	1995 YEA	3. TIME OF DEATH 1:25 A M
P	15	4. SOCIAL SECURITY NUMBER 215-18-4026	1 □ M 2 🖾 F 9	(In yrs. last birthday)	F UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTH (Month, Day, Ybar) DEC. 14,	0. Bi	IRTHPLACE (State or Foreign ountry)
. 2, 3 should	TOR	98. FACILITY NAME (If not institution, give MALLARD BAY NURS) RESIDENCE OF DECEDENT		CENTER	96. CITY, TOWN CAMBRI	DGE	ATH	DORCHE	
permit. Pages 1,	DIRECTOR	MARYLAND TALI			TRAPPE	CATION	-		10d. INSIDE CITY LIMITS? 1 🖾 YES 2 🗌 NO
35.	FUNERAL	3961 SCHOOL STRI	EET	_		101. ZIP CODE 21673			DE WHAT COUNTRY?
215-0020 attending physician. se as the burial-transit	₽	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 TYES IF YES, GIVE WAR OR D.	2 NO	If yes,	ECENDENT OF HISPAN specify Cuben, Mexica ES 2 1 NO Specify		В	RACE — American Indian, Black, White, etc. Specify: WHITE
21 al or for u	PLETED	15. DECEDENT'S ED (Specify only highest grade) Elementary/Secondary (0-12)		Itte. Do NOT u	work done during i	TION most of working	166. KIND OF BU	SINESS/INDUSTR	ny .
BALTIMORE, MARYLAND 2 ler death. Page 6 may be retained by the hospital the tuneral director, page 5 should be detached for real.	BE COMPL	17. FATHER'S NAME (First, Middle, Leat) SAMUEL BLUNT SKI	NNER			HEN	ME (First, Middle, Melden RIETTA CAI	LLAHÁN	
RE, MAR may be retained or, page 5 should set be notified	5	BARBARA A. PRICE		3961	SCHOOL	STREET, T	RAPPE, MD	21673	
ALTIMORE, death. Page 6 may be tuneral director, page I.		20a. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE I	movel from State	OUDLAWN	MEMORIA	Name of L PARK AND ADDRESS OF FA	7/19 EAS	STON, MA	
BALTIMO after death. Page 6 by the funeral directo moval.		· B. Kert	I Phypon		P NEWN 200	AM FUNERA S. HARRIS	L HOME, P. ON ST., EA	1010,	Ф 21 6 01
760, ad within 24 nours ompletely filled in b. I, cremation, or rei		23. PART i. Enter the diseases, or shock, or heart failure iMMEDIATE CAUSE (Final disease or condition resulting in death)	a. DUE TO (DR AS A	CONSEQUENCE O	Liun			iratory arrest,	Approximate interval Between Onset and Death
P.O. BOX 68 th certificate be execu- ending physician and a I Hygiene prior to burn or other traumatte	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	20 GENICA CONSEQUENCE O	BRain	SyNO	laume		Though Tyears
RDS at the d by the ind Me	SAL	PART II. Other significant condition Athere o Sc/e	ons contributing to death b		In the underly	ing cause given in	Part I. 24a. WAS AN PERFOI		24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE
. ≥ 5 6	N: MEDIC	Degenerati Ostonory	ie Joint	Diseas			1	t ∭ NO	OF DEATH?
TA The ste h	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND	HOSPITAL: 1 Inpatient 2 ER/Outp	patient 3 DOA	OTHER:	PLACE OF DEATH (Ch			
NG PHYSICIAN: Ther this certificate that with the St marked, or II	ВУ РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIN	IE OF 28c. II	NJURY AT YORK? YES 2 ND	28d. DESCRIBE HOW	INJURY OCCURED)
TISIC TTENOI TTENOI TTOR: A after d	ETED E	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE DF INJURY building, etc. (Spec	f — At home, lerm, cify)	street, factory, of	fice	261, LOCATION (Street City or Town, State)	and Number or Rui)	ral Route Number,
4 7 Z =	COMPL	one) 2 MEDICAL EXAMIN	SICIAN: To the best of my know NER: On the basis of examination						se(e) and manner as stated.
TO THE HOSPIT TO THE FUNERA De filed within ?	TO BE	296. SIGNATURE AND TITLE OF CERTIFI	Horns M.	D.		D-43	707	≥ OATE SIGN	NED (Month, Day, Year)
		ROSEMARY M.	HARRIS, M.D	., 408		ST., CAM	BRIDGE,	MD 216	513
		JUL 1 9 1995	32. REGISTRAR'S SIGN	Kardall					



for use as the burial-transit ital or attending physician. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without a first fours after death. Page 6 may be retained by the hospit TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cereation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Initory, or other tranmatic event, the medical examiner must be notified at once.
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2

Amm on a

9 1995

31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kioumarce Yazdani M.D.

0

32. REGISTRAR'S SIGNATURE Daviden Rardall

Prince Frederick, Md.

20678

Pages 1, 2, 3 should

permit.

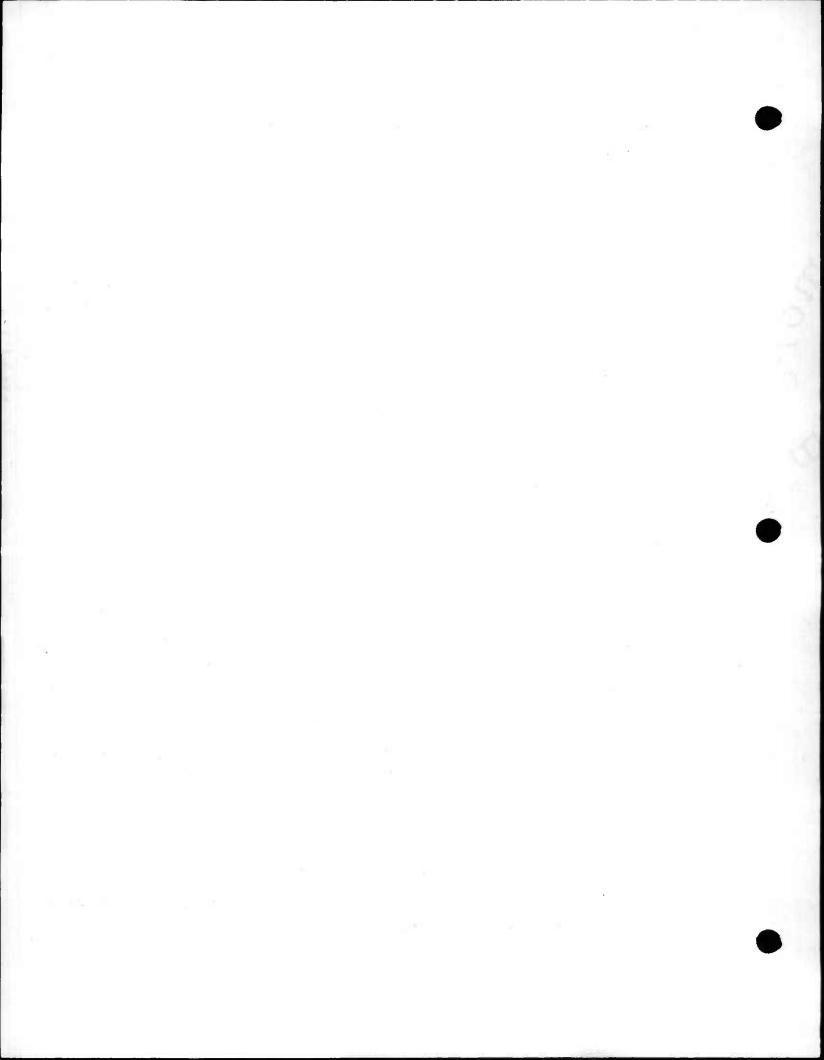
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Alice 14, 1995 1105 A Cook July 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 217-34-2152 1 M 2 X F 78 October 1,1916 Maryland 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Calvert Memorial Hospital Prince Frederick Calvert RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Calvert Sunderland 1 TES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7570 Wayside Drive 20689 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES . 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 ☐ YES 2 🕅 NO Specify: 1 Never Married 2 Merried BY Specify:Black 3 X Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) st of working ntary/Secondary (0-12) College (1-4 or 5+) Housewife Own home once. 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Meiden Sumeme) at BE Harry Jones Mary Μ. Chambers notified a 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5 Delphine E. Cooke 7570 Wayside Drive Sunderland, MD 20689 2 20e, METHOD OF DISPOSITION
1 Suriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Hope UM Chr. Cem. 7/19/95 Sunderland, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD medical 23. PART I. Enter the disesses, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. intarval Between IMMEDIATE CAUSE (Final Onset and Death the disesse or condition_ DUE TO (OR AS A CONSEQUENCE OF): meta reaulting in death) event, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 Injury, PART II. Other significent conditions contributing to deeth but not reaulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? апу 1 YES 2 1 NO shows 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL: **EXAMINER?** OTHER: 1 YES 2 WHO 1 IV Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28e, DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural BY 1 YES 2 NO 2 Accident Investigation 3 Sulcide 28e. PLACE OF INJURY — At home, farm, etreet, fectory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 Is COMPLETED 6 Could not be determined 4 Homicide 29e. CERTIFIER
(Check only one)

1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. MEDICAL EXAMINER: On the basis of axar nination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and manner as stated. BUSICHATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIONED (Mgnth, Day, Year) BE 45

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR	STATE OF I	MARYLAN	D / DEPAR	RTMEN'	OF H	IEALTH DEA	AND I	MENTA	L HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH				3. TIME OF DEATH
	KELLY	LYNN	LYNN COX						JULY 02,1995			5	15:20 P
	4. SOCIAL SECURITY NUMBER	5. SEX		s. lest birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH		6. BIRTH	PLACE (State or Foreign
	215-11-4551	1 M 2 K F	1.	3 YRS.						23, Year)	981	GO]	dsboro, NC
CTOR	99. FACILITY NAME (If not Institution, give street end number) 99. CITY, TOWN OR LOCATION OF DEATH 5165 CHRISTIANA PARANN RD. SUNDERLAND CALVERT												
DIREC	PESIDENCE OF DECEDENT 10a. STATE VA 10b. COUNT	Y		10c. CITY, TOWN OR LOCATION Newport News						<u> </u>			10d. INSIDE CITY LIMITS? 1X YES 2 NO
FUNERAL	100. STREET AND NUMBER 510 B Bellfield						zip cod	602			1170	IZEN OF W	HAT COUNTRY?
B	11. MARITAL STATUS 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	X NO	MED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — 14. H 19. specify Cuben, Mexican, Puerto Rican, etc.)						14. RACE Black Specif	- American Indian, . White, etc.		
	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5		(Give kind of	(Give kind of work done during most of working life. Do NOT use retired.)					. KIND OF BU	ISINESS/IND	DUSTRY	
E COMPLEIED	17. FATHER'S NAME (First, Middle, Lest)	17. FATHER'S NAME (First, Middle, Lest)								Middle, Maiden			
)	190. INFORMANT'S NAME (Type/Print) DePaula Cox	19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 above											
	20b. PLACE AND DATE OF DISPOSITION 1-8 Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) So. Memorial Gardens July 7,1995 Dunkirk, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE												
	► William R.							ne, P.A	A., O	wing	s, MD		
	23. PART 1. Enter the diseases, or capacity shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)										Approximate interval Betwee Onset and Dast		
CERTICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):												
AL	PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO										WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN S. WAS CASE REFERRED TO MEDICAL EXAMINER? 125. WAS CASE REFERRED TO MEDICAL EXAMINER? 126. PLACE OF DEATH (Check only one) 127. PLACE OF DEATH (Check only one) 128. PLACE OF DEATH (Check only one)												
ВУ РНУ	1 Netural 5 Pending 2 M Accident Investigation	28e. OATE OF (Month, D. 7-2-95	INJURY ay, Year)	28b. TIM		28c. INJU	JRY AT		e □ Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED Inhaled Carbon monoxide fumes			nhaled mes	
	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined		treet, facti	**			281. LOCATION (Street and Number or Buyel Route Number, City or Rown, State) 5165 Christian Parran Rd., Sunderland MD						
COMPLET	29e. CERTIFIER (Check only 000) MEDICAL EXAMINE							end due	to the ceu	ise(e) end mer	nner ee state	ed.	
TO BE	29s. SIGNATURE AND TITLE OF CERTIFIES	locko	-eM	0				nse num ME	BER				(Month, Day, Year)
	OCME JULY 03,199 OCME JULY 03,199 OCME AUGUST OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 2120											d 21201	



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

George

5 SEY

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 🕅 M 2 🗌 F 171-26-9478 Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give atreet and number, 9b. CITY, TOWN OR LOCATION OF GEATH DIRECTOR Frederick Memorial Hospital Frederick RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION Maryland Frederick Frederick page 5 should be detached for use as the burial-transit permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 9057 Allington Manor Circle, West 21701 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX YES 2 ☐ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 1 Never Merried 2 X Married BY 3 Widowed 4 Divorced 1957-1960 16a. DECEDENT'S USUAL OCCUPATION

16a. DECEDENT'S USUAL OCCUPATION

Working distributed of working most of working COMPLETED 15. DECEDENT'S EDUCATION (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Owner and Operator 17. FATHER'S NAME (First, Middle, Leet) notified at Willis R. Couchenour BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Janet M. Wright Couchenour 9057 Allington Manor Circle, West Frederick, MD pe 20e METHOD OF DISPOSITION
1 D Burial 24 Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of must OATE metery, cremetory or other plece)
Hagerstown Crematory 4 Donation 8 Other (Specify) 7/19/95 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 1621 Opossumtown Pike, Frederick, MD and completely filled in by the I burial, cremation, or removal medical 23. PART I. Enter the diseases, or complications that ocused the deeth. Do not enter the mode of dying, such as cerdiec or reepiretory strest, ehock, or heart feliure. List only one cause IMMEDIATE CAUSE (Finel event, the disease or condition resulting in death) CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): ULMONARY FMBOLISM traumatic CERTIFICATION Sequentially list conditions. 10 DUE TO (OR AS A CONSEQUENCE OF) If any, leeding to immediate death certificate be been signed by the attending physician or, of Health and Mental Hygiene prior to THROMBOEMBOLISM cause. Enter UNDERLYING DEEP VENOUS CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST 6 VENOUS PART II. Other eignificent conditions contributing to deeth but not recuiting in the underlying ceuse given in Part I. MEDICAL any MRTERY DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN I PHYSICIAN: has by Dept. HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h HOSPITAL: OTHER 1 YES 2 NO atlent 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY marked. 28c. INJURY AT this c 1 Natural 7 - 16-5 Pending 1141 PM ВУ 1 YES 2 NO After 1 death 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Sulcide ETED 69 DIRECTOR: A 8 Could not be 4 Homicide 28 determined Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, and due to the ceuse(e) end manner as atsted. COMPL TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h (Check only one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date and piece, end due to the ceuse(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER much MiD. D41625 2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAD'S SIGNATURE

STEVEN NAGEL M.D.

JUL 1 9 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

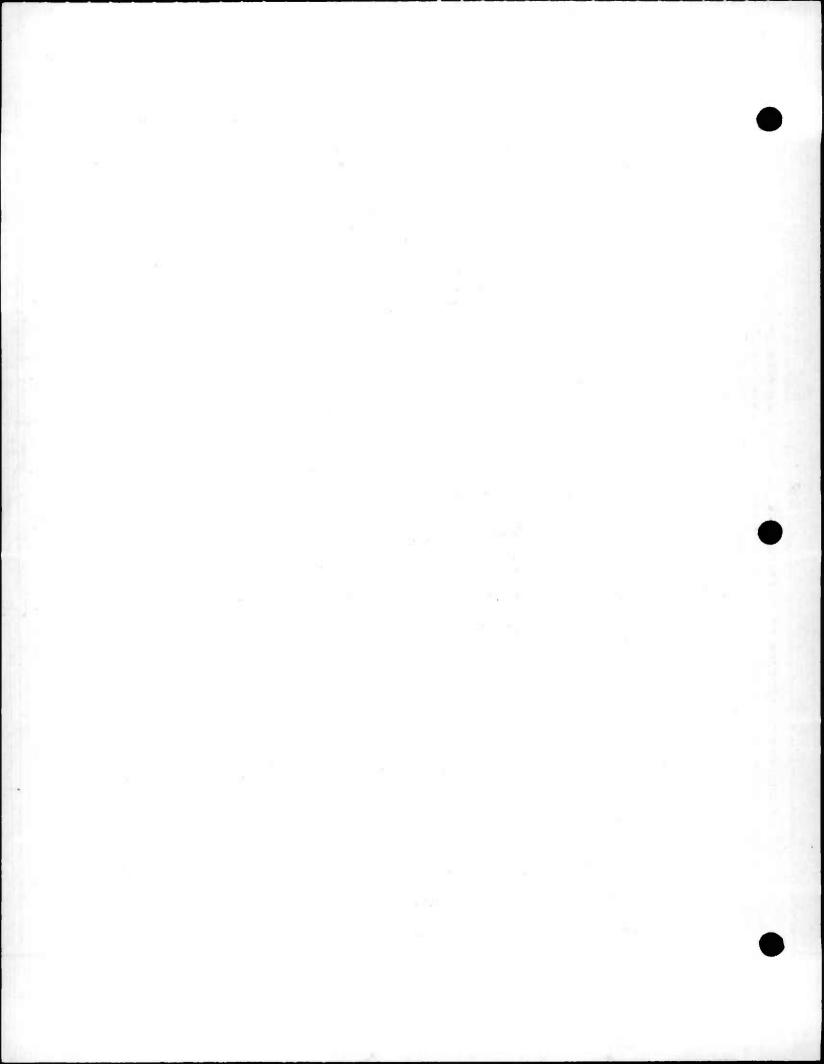
IF UNDER 1 YEAR

IF UNDER 24 HRS.

Couchenour

6. AGE (In yrs. last birthday)

REG. NO 2. DATE OF DEATH 3. TIME OF DEATH 1995 11:41 July 16 PM 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign June 21, 1935 Pennsylvania 9c. COUNTY OF DEATH Frederick 10d. INSIDE CITY 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indien, Black, White, etc. Specify: White 16b. KIND OF BUSINESS/INDUSTRY Towing Business Margaret Catherine Householder 21701 20c. LOCATION — Cify or Town, State Hagerstown, Maryland Stauffer Funeral Homes, P.A Approximete Interval Between Onset and Death 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 TYES 2 THO 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) 915 TOLHHOUSE AVE FREDERICK MD 21701 DHMH-16 Rev 1/89



BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

Sequentielly list conditions.

If any, leading to immediate

cause. Enter UNDERLYING CAUSE (Disease or Injury

that initiated eventa resulting in death) LAST

27. MANNER OF DEATH

1 Natural

2 Accident

3 Suicide

4 Homicide 29a. CERTIFIER

(Check only one)

						95	23159				
	1 - STATE OF MARYLAND / CI			HEALTH AND I	MENTAL HYGIEN REG. NO.	_					
		ROSS			2. DATE OF DEATH DATE OF DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DEATH DATE OF DATE	0 199	0 0 0				
	229-44-8747 1 X M 2 □ F 60		IF UNDER 1 YEAR MONTHS DAY	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec. 7, 193						
	9e. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOW	N OR LOCATION OF DE		9c. COUNTY					
DIRECTOR	Shady Grove Adventist Hospit	:a1	Roc	kville		Mo	Montgomery				
Œ	10s. STATE 10b. COUNTY	10c. CITY	, TOWN OR LO	CATION			10d. INSIDE CITY				
	Maryland Montgomery	Ga	aither	sburg			LIMITS?				
M	10e. STREET AND NUMBER			tor. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?				
JE F	17 Water Street - #5			20877		U.S	.A.				
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EYER IN U.S. AR FORCES? 1 YES 2 X IF YES, GIVE WAR OR DATES						14. RACE — American Indian, Black, White, etc. Specify: White				
TE	(Specify only highest grade completed) (G		USUAL OCCUPA fork done during		16b. KIND OF BUS	16b. KIND OF BUSINESS/INDUSTRY					
COMPLETED				Engineer	Retire	ment	Village				
BE CO	17. FATHER'S NAME (First, Middle, Last) Stuart L. Cross										
10	196. INFORMANT'S NAME (Type/Print) Catherine Virginia Cross 19 Mailing Acoress (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20877 17 Water Street - #5, Gaithersburg, Maryland										
	20e. METHOD OF DISPOSITION 12 Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Fores	and date of the total	FDISPOSITION her plecel K Cem	Name of etery	1	ither	or Town, State sburg, Md.				
21. SIGNATURE OF FUNERAL SERVICE LICENSES, Williams 22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A., Funeral 26401 Ridge Rd., Damascus, Mary											
	23. PART I Enter the diseases, or complications that caused the de ahock, or heart feliure. List only one cause on each line IMMEDIATE CAUSE (Finel	eth. Do no	ot entar the	noda of dying, auci	as cerdlec or reepi	retory arrest,	Approximate interval Between Onset and Death				
	disease or condition resulting in death)	0-0	aln	Laury	arrest	-	min				

PART II. Other algolificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. obstru ve isease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | UNCERTAIN S

DUE TO (OR AS A CONSEQUENCE OF):

OUE TO (OR AS A CONSEQUENCE OF

OUE TO (OR AS A CONSEQUENCE OF):

ritoriti

24a. WAS AN AUTOPSY PERFORMED?

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH?

29d. DATE SIGNED (Month, Day, Year)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

1		YES	2		NO	
---	--	-----	---	--	----	--

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA 1 - YES 2 NO

26s. DATE OF INJURY (Month, Day, Year)

OTHER:

gastric

Home 5 - Residence 6 - Other (Specify)

28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO

riedge, death occurred at the time, date end place, end due to the cause(e) end menner ee atated.

28b. TIME OF

28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, atc. (Specify)

on and/or investigation, in my opinion, death occured at the time, data end place, end due to the ceuse(s) end menner ee stated. 29b. SIGNATA RE AND TITLE OF CERTIFIES

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert

FOX Rockville, Und. 9715 Dri med.

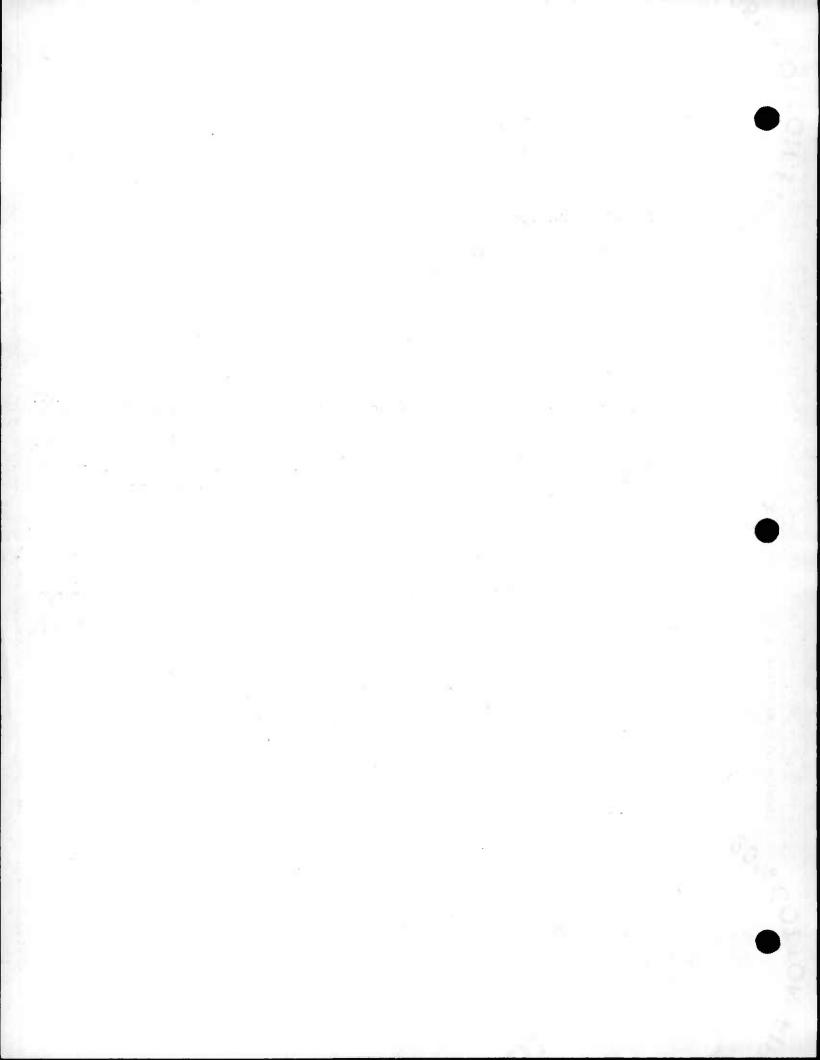
29c. LICENSE NUMBER

31. DATE FILED (Month, Day, Year)

JUL 1. 9 32. REGISTRANS SIGNATURE

Pending Investigation

8 Could not be



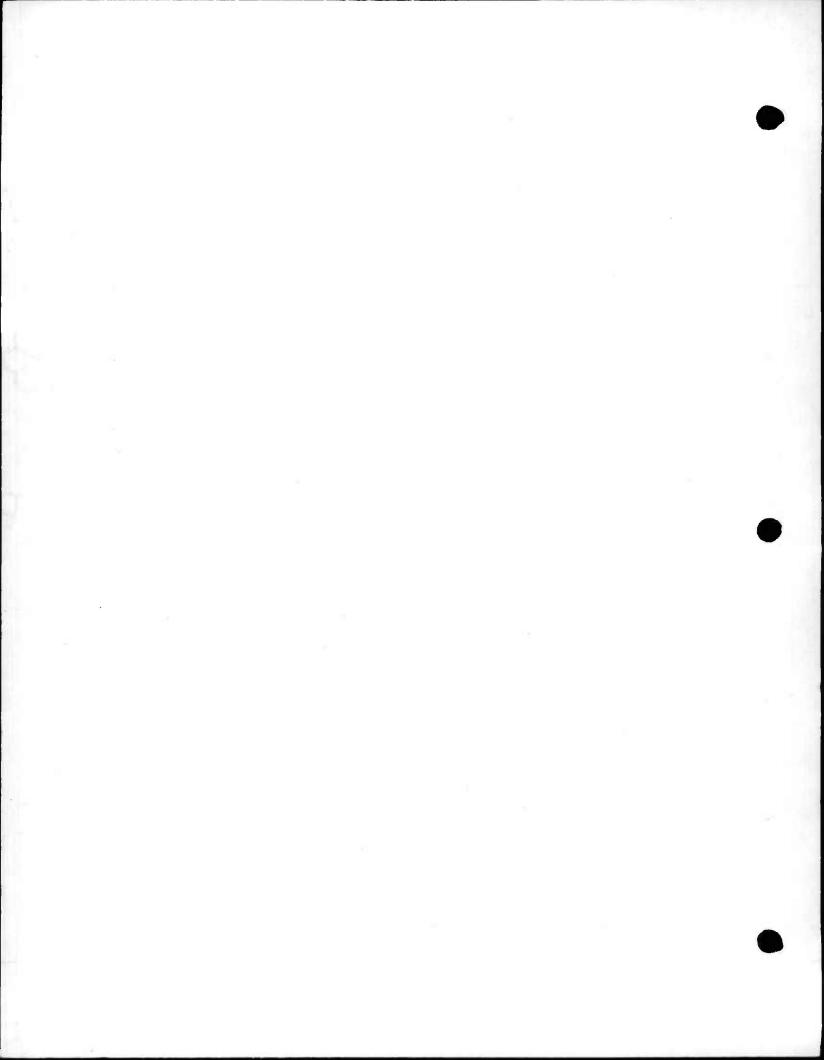
		1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	ICATE (F HEALTH AND OF DEATH	MENTAL HYGIEN REG. NO						
		1. DECEDENT'S NAME (First, Middle, Last) ZHANE	RASHA		C.F	ANN	2. DATE OF DEATH DO NORTH DO N	7 , 199	3. TIME OF DEATH 1:18 A M				
Pla		4. SOCIAL SECURITY NUMBER 213-43-5391	1 M 2 X F	yrs. last birthday) YRS.	MONTHS DA	YS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept. 18,		BIRTHPLACE (State or Foreign Country) Maryland				
, 2, 3 should	TOR	9a. FACILITY NAME (If not institution, give FREDERICK MEMO		'AL	96. CITY, TOWN OR LOCATION OF DEATH FREDERICK FREDERICK								
permit. Pages 1,	DIRECTOR	10a. STATE 10b. COUNT Maryland F1		ry, town on Lo			10d. INSIDE CITY LIMITS? 1 Y YES 2 NO						
. ISI	FUNERAL	100. STREET AND NUMBER 201 Madison Stre	100. STREET AND NUMBER 201 Madison Street Apt. 98				101. ZIP CODE 21701						
215-0020 attending physician. se as the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	Never Married 2 Merried FORCES? 1 YES 2 N				ARMED 13 WAS DECEMBENT OF HISPANIC ORIGINS (Specify Years) No. 14						
2 2 2	PLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	UCATION to completed) College (1-4 or 5+)	16a. DECEDENT'S (Give kind of life. Do NOT u	work done during	Black							
YLAND 2. by the hospital o be detached for at once.	COMP	17. FATHER'S NAME (First, Middle, Last) Frederick A. Car					AME (First, Middle, Maiden						
MARY retained to 5 should notified	TO BE	19a. INFORMANT'S NAME (Type/Print) Stephanie G. Boyo				Stephanie G. Boyce ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) adison Street Apt. 98 Frederick, MD 21702							
IORE, I e 6 may be e ector, page 5 must be n		20a, METHOD OF DISPOSITION 1 ABurlal 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	20b. P	LACE AND DATE	OF DISPOSITION	N (Neme of	DATE 20c. LO	CATION — City	y or Town, Stata				
BALTIMOR after death. Page 6 m. y the funeral director, moval.		21. HONARDHE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P. A 1621 Opossumtown Pike Frederick, MD 21702											
hin 24 hours tely filled in t mation, or res t, the media		23 PART Letter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that caused it. List Drily one cause on each accordance as CONGENITAL HE	ART DISE	ASE	mode of dying, suc	h as cardiac or respi	ratory arrest	t, Approximate Interval Between Onset and Death				
S, P.O. BOX 68760 death certificate be executed within attending physician and completel ental Hygiene prior to burial, cremany, or other traumatic event,	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	bDUE TO (OR AS A CO										
ADS fr the d by the nd Mei	MEDICAL C	PART ii. Other aignificant condition	ns contributing to death but	not resulting	in the underl	ying cause given in	Part I. 24a. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
L RE law requi as been s ept. of H 23 shov		DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	26.	DEATH YE			NO		1 TYES 2 NO				
FVITA rSICIAN: The certificate h th the State I	PHYSICIAN:	EXAMINER? XIX YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 □ Inpatient 2X NER/Outpath 28a. DATE OF INJURY	28b. TIM	E OF 28c.	Home 5 Residence	8 Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCUF	RED				
DIVISION OF VITA OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate his nours after death with the State D Item 28 is marked, or Item	ED BY P	1 X Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28. PLACE OF IN HIRV	- At home, farm, s	M 1	WORK?	28f. LOCATION (Street a City or Town, State)						
NL OR	COMPLETE	29a. CERTIFIER (Check only 1 CERTIFYING PHYS	SICIAN: To the best of my knowled						ause(a) and manner as stated.				
TO THE HOSPITA TO THE FUNERA De filed within 7 IMPORTANT: 1	TO BE CO	29b. SIGNATURE AND TITLE OF CERTIFIE	er M. Kr	1 11	<i>m</i>	29c. LICENSE NUI	MBER	29d. DATE SI	IGNED (Month, Day, Year) LY 16, 1995				
			4.Kinst 1	11 Pen		eet, Bal	timore,	Maryl	and 21201				
- 1		31. DATE FILED (Month, Day, Year)	OE 32. REGISTRAR'S SIGNATI	URE P	40								

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SINISION OF VITAL RECORDS, P.O. BOX 88760	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending pay	Configuration and the first transfer of the
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	1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPA CERTI	RTMENT 0 FICATE (F HEALTH AND OF DEATH	MENTAL HYGIEN REG. NO					
	1. OECEOENT'S NAME (First, Middle, Last) Baby Girl	Chigbo				2. DATE OF DEATH JULY 24	^ 19 ^t	3. TIME OF DEATH 95 06:30 P M			
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AG	AE (in yrs. last birthday YRS.	MONTHS DA		7. DATE OF BIRTH (Mornth, Day, Year) July 16,		BIRTHPLACE (State or Foreign Country)			
	9e. FACILITY NAME (If not institution, give str				VN OR LOCATION OF O		9c, COUNTY	Baltimore OF DEATH			
1 2	The Johns Hopkin	s Hospital		Balt:	more Cit	У					
DIRECTOR	10e. STATE 10b. COUNTY		10c, C	ITY, TOWN OR LO	CATION			10d. INSIDE CITY			
1	Maryland Maryland		Ва	1timore				1 THE 2 NO			
HAL	100. STREET AND NUMBER 60 Ambo Circle				101. ZIP CODE 21220		10g. CITIZEN	OF WHAT COUNTRY?			
BY FUNERAL	11. MARITAL STATU8 1 \[\times \times \text{Never Married} 2 \text{Merried} \text{3} \text{Widowed} 4 \text{Divorced} align*	12. WAS OECEDENT EVEI FORCES? 1 YE IF YES, GIVE WAR OR	S 2 VNO	If yes			or No— 14.	RACE American Indian, Black, White, etc. Specify: Black			
PLETED	15. OECEDENT'S EDUC/ (Specify only highest grade of Elementary/Secondary (0-12)	ATION ompleted) College (1-4 or 5+)		S USUAL OCCUP f work done during use retired.)		16b. KINO OF BUS	SINESS/INDUST	TRY			
BE COMPLET	17. FATHER'S NAME (First, Middle, Lest) Chukwura Elue				16. MOTHER'S NA	AME (First, Middle, Malden Chigbo	Surrieme)				
TO E	19m, INFORMANT'S NAME (Type/Print) Kanny Chigbo		19b. MAILIN 60 A	mbo Cir	cle, Balt	Aoute Number, City or Tow	yland 2	⁽ⁿ⁾ 21220			
	20e. METHOD OF DISPOSITION 1 Burlet 2 A Cremation 3 Remov		00. PLACE AND DAT		I (Name of	OATE 20c. LO	CATION — City	or Town, State			
	4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE		The John	s Hopki	ns Hospit.	a1 7/24/95	Baltin	more, Maryland			
	23. PART i. Enter the diseases, or co shock, or heart feliure. Li IMMEDIATE CAUSE (Finel disease or condition resulting in death)	st only ona csuse on	sed tha daath. Do eech line.	ny 1:	h as cardiac or reapl	ratory arreat,	Approximata interval Between Onset and Death				
CERTIFICATION	Sequentisliy list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet initieted events resulting in death) LAST		S A CONSEQUENCE								
MEDICAL C	PART II. Other significant conditions	contributing to deeth	but not resulting	In the underi	ying couse givan in	Part I. 24e. WAS AN PERFOR	MED?	24b, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
Ä	DID TOBACCO USE CONTRI	BUTE TO CAUSE		ES NO	UNCERTAI	N 🗆		<i>N</i>			
SICI	EXAMINER?	HOSPITAL:	26. PLACE OF DE	OTHER:							
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF INJUR (Month, Day, Year	Y 28b, TI		INJURY AT	5 ☐ Other (Specify) 28d. OEŞCRIBE HOW II	NJURY OCCURE	ED .			
ВУ	1 Natural 5 Pending 2 Accident Investigation			M 1	WORK? YES 2 NO						
ETED	OSA BUADE OF INDIANA							lural Route Number,			
COMPLE		AN: To the best of my kno						use(s) and menner as stated.			
O BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	f. Cho	MD		29c. LICENSE NUI			SNED (Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO	CINO	DEATH (ITEM 27) (Typ		hns Hook	in Neona	tal	ICU			
	31. DATE FILED (Month, Day, Young) 32. REGISTRARS SIGNATURE PAUL OF THE PROPERTY OF THE PROPER										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

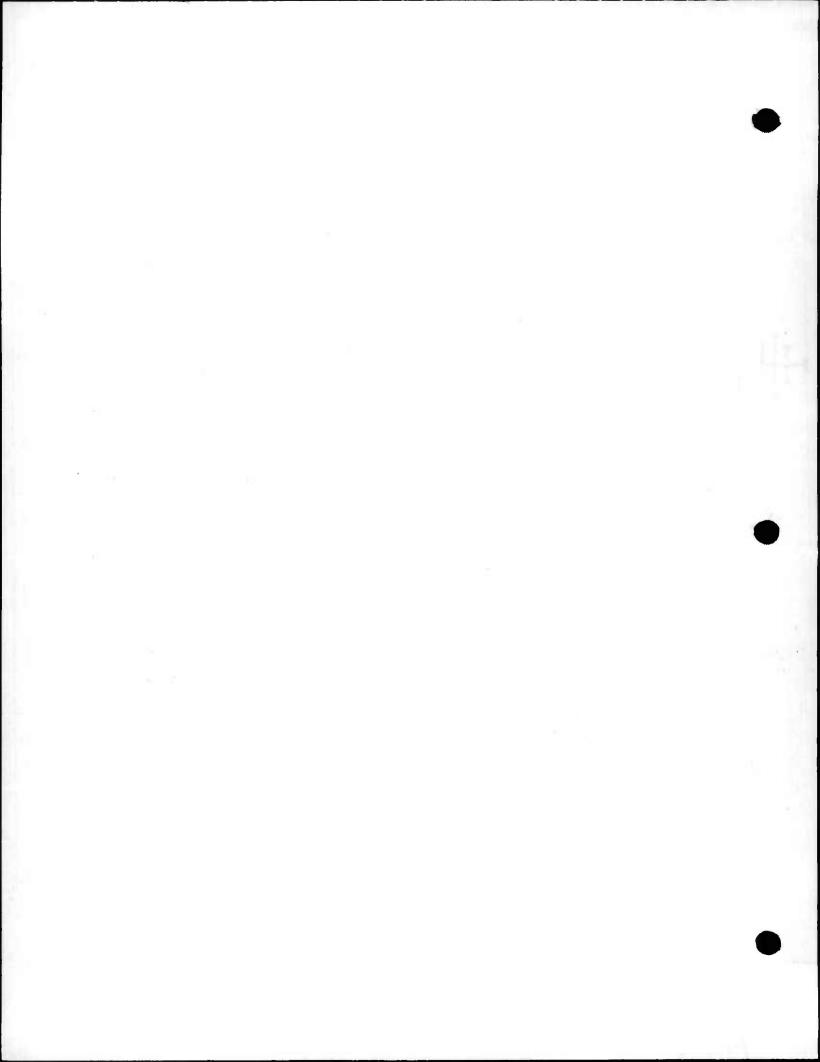
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

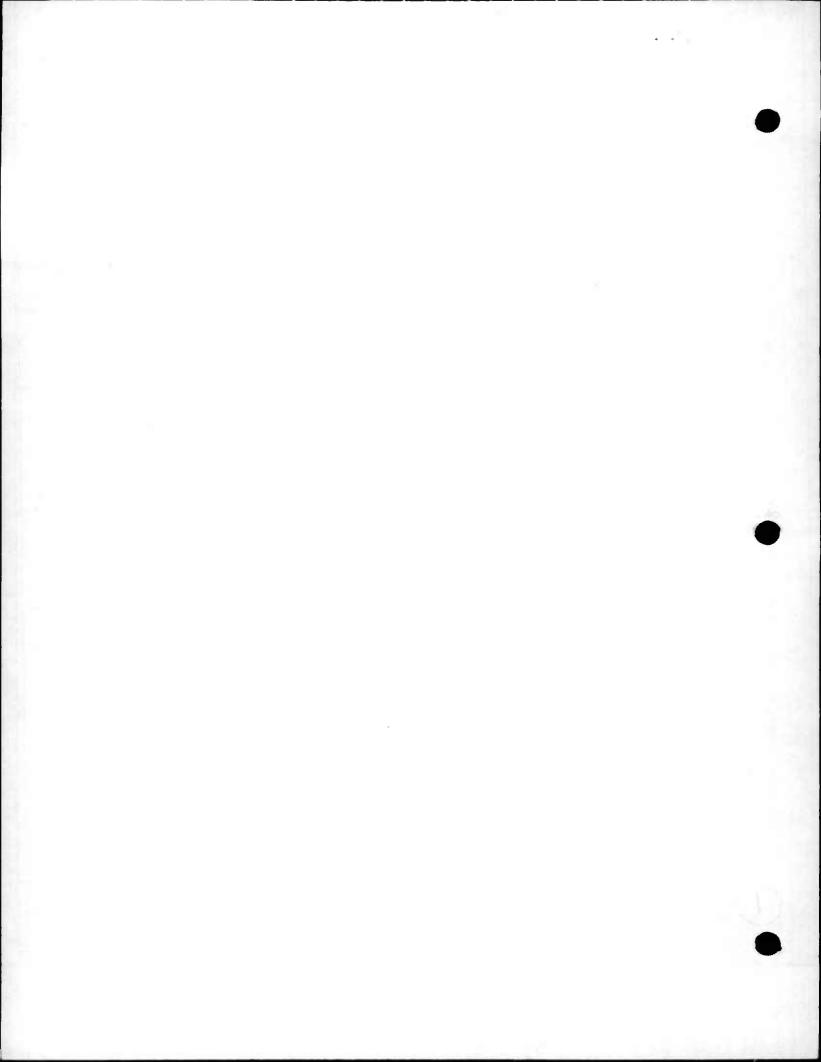
1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

_	HEGISTHAN			EKIIF	CALE	OF DEAT	Н	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH	3. TIME OF DEATH			
	MILDRED	Louise CAR			NTER			MONTH DAY YEAR			6:15 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yrs. les		IF UNDER 1 YE	AR IF UNDER 2		7. DATE OF BIRTH	995	e pipti	HPLACE (State or Foreign
	216-30-3135	1 M 2 X F		1 YRS.	MONTHS DA		MIN.	June 9, 19	Month, Day, Year) Ine 9, 1934 Maryland		
	9e. FACILITY NAME (If not institution, give str	reet and number)			9b. CITY, TO	N OR LOCATIO	N OF DEA	ATH	9c. COU	INTY OF D	DEATH
8	Memorial Hospi	tal			Cum	berland	đ		l a	11eg	anv
5										,	
DIRECTOR	Maryland All			mberla						10d. INSIDE CITY LIMITS? 1 YES 2 NO	
	10e. STREET AND NUMBER					10f, ZIP CODE			40 - CIT	175N 05 1	WHAT COUNTRY?
ER/	Finan Center				502		A.				
5	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. AR	MED	13. WAS	DECENDENT OF	HISPANIC	C ORIGIN? (Specify Yes	or No —	14. RACI	E — American Indian
BY FUNERAL	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1		10	II yes	, specify Cuban YES 2 A NO	, Maxican,	Puarto Rican, etc.)		Spec	E — American Indian, k, White, atc. s/y: White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	18a. DE	CEDENT'S	USUAL OCCUP	ATION most of working		18b. KIND OF BUS	INESS/INI	DUSTRY	
	Elementary/Secondary (0-12) 0-12	College (1-4 or 5+)	life.	Do NOT us	retired.)	most or wonding	,				
MP	0-12	0		secre	tary			Insurar	ice (Compa	iny
8	17. FATHER'S NAME (First, Middle, Last)					18. MOTH		E (First, Middle, Maiden			
BE		Hess, Sr	•				M:	ildred P.	Leed	ly	
2	19a. INFORMANT'S NAME (Type/Print)		198	b. MAILING	ADDRESS (Str	et and Number o	or Rural Ro	oute Number, City or Town	n, State, Zip	D Code)	
-	Mrs. Doris L. Smi	th	39	99 Ke	y Circ	le, Ha	gers	town, Mary	land	1 21	1740
	20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ramo	val from State	20b. PLACE	AND DATE O	F DISPOSITION	(Name of		DATE 20c. LO	CATION —	City or To	own, Stata
y I	4 □ Donetton → □ Pither (Specify) Cedar Lawn Memorial Park 7-25-95 Hagerstown, Maryland										
	21. SIGNATURE OF SONEBAL SERVICE LICE	highe 1						urMinnich			
	- Kohes X	1 Ha	me	>	415	East W	ilso1	n Blvd., F	lager	stow	n, MD 21740
	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest,										
ı	shock, or heert feilure. List only one cause on each line. IMMEDIATE CAUSE (Final Onsat and Death										
	disease or condition										9 hours
ĺ	Troubling in double,		AS A CONSEC								J Models
z											
CERTIFICATION	Sequentially liat conditions, if any, leading to Immediate DUE TO (OR AS A CONSEQUENCE OF):										
2	CAUSE (Disease or injury										
# 1	thet initieted events resulting in death) LAST	DUE TO (OR	AS A CONSEC	DUENCE OF):						
E	d d										
2	PART II. Other significant conditions	contributing to de	ath but not n	esulting i	the underi	dno cause di	ven in P	art I. 24a, WAS AN	ALIMAREY	1 245	WERE ALTOROV CHIRDINGS
MEDICAL				oonling .	, the onder	ing cause gi	van ni F	PERFOR	MED?	240.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
								1 YES 2	NO		DF DEATH?
- 10	DID TOP ACCOUNTS	IDLITE TO CALL			prop 1 1 m	_/		{			1 TES 2 NO
AN	DID TOBACCO USE CONTR	IBUIL IO CAUS					RTAIN				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER:	ne)					
YS	1 VES 2 NO	1 Inpatient 2 - EF			4 - Nursing I	loma 5 🗆 Rasi	idenca 8	Other (Specify)			
표	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJ (Month, Day,)		28b. TIME INJU		INJURY AT WORK?	2	28d. DEŞCRIBE HOW IN	JURY OC	CURED	
B	2 Accident investigation					YES 2	NO				
	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF IN building, atc.	JURY — At hor (Specify)	me, farm, si	reet, factory, o	ffice	3	28f. LOCATION (Street as City or Town, State)	nd Number	or Rural R	Poute Number,
Fi F	Mar CERTIFIED								<u>.</u>		
로	29e, CERTIFIER CERTIFYING PHYSIC										
COMPLETED	one) 2 MEDICAL EXAMINER	On the basis of exami	nation and/or le	nveatigation	, in my opinio	, death occured	d at the tir	me, data and placa, and	due to th	ie cause(a) and manner as stated.
w II	296. SIGNATURE AND TITLE OF CERTIFIER	2 /		1		29c. LICEN	ISE NUMB	ER I	29d. DAT	E SIGNED	(Month, Day, Year)
∞ 	Moleustino (I Mour	66	(/	hus	D 148		1	> /	. 0.	
٤	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	F DEATH (ITEN	fr (typic	Print)	D 140			97	vy-	23,1995
	Dr. R. Barrera	Memorial F	lospita	1 Me	dica1	Bldg. (Cumbe	erland, MD	215	02	
İ	31. DATE FILED GAVING TOOK	A PARENTENANTE	March 199			0.					
- 1	JUI 24 1995 36	A CONTRACTOR OF	- Contract								



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR DORA E. DOZIER JULY 1995 2:45 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in vrs. last birthday 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 M 2X F 113-44-5564 South Carolina Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PRINCE GEORGE"S HOSPITAL Cheverly George's Prince RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Prince George's Capital Heights 1 TYES 2 TENO permit. FUNERAL 10e STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 505 Suffolk Avenue #111 20747 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Mexican, Puerto Rican, atc.)
 U YES NO Specify: 14. RACE — American Indian, Black, Whita, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married A 3 Widowed 4 Divorced Black 16a. OECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18b. KIND OF BUSINESS/INOUSTRY ive kind of work done
Do NOT use retired ! Elementary/Secondary (0-12) College (1-4 or 5+) 12th Housewife Private 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Samuel Dozier BE Dora -DOZIER 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Alberteen Jenkins 3218 8th Street S.E. #303 Washington D.C. 20032 Pe 20a. METHOD OF DISPOSITION
1 XPOTAL 2 CONNEction 3
Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of PATE 95 20c. LOCATION - City or Town, State must Harmony Memorial Park July20 Landover, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home n by the fi removal. 7474 Landover Rd. Landover. 20785 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, filled in by Approximata ahock, or haart failure. List only one cause on each line ö Intervel Between IMMEDIATE CAUSE (Final Onaat and Death n and completely fille to burial, cremation, the disease or condition resulting in death) PULMONARY EMBOLISM event. DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION POST SURGICAL Sequentially list conditions, DUF TO (OR AS A CONSEQUENCE OF) been signed by the attending physician at the other than the Health and Mental Hygiene prior to If any, leading to immediate requires that the death certificate be cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 PART II. Other algoriticent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 1 TES 2 NO shows a 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN M has b. Dept. PHYSICIAN: DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL: certificate t OTHER: 1 TES 2 THO Inpatient 2 - ER/Outpatient 3 -DOA 4 Nursing Home 5 Realdence 6 Other (Specify) 10 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked. this (1X Natural 5 Pending Investigation 1 YES 2 NO BY After 2 Accident 28a. PLACE OF INJURY — At home, ferm, atrast, factory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 00 COMPLETED 6 Could not be DIRECTOR: / 4 Homicide 28 29a. CERTIFIER 1 😿 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the films, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL I
Be filed within 72 h
IMPORTANT: If i HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurse at the time, data and place, and due to the cause(s) and manner as stated. HE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) **BE** nex 01773 7/17/95 2 COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print) Grigorian 6001 Landover Rd. Cheverly,MD 20785 32 REGISTRAR'S SIGNATURE



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5 sho	notiff
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the S	10
r this	arked
: Afte	is m
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at on
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31. OATE FILED (Month, Day, Year)

JUL 20 1995

is 1, 2, 3 should

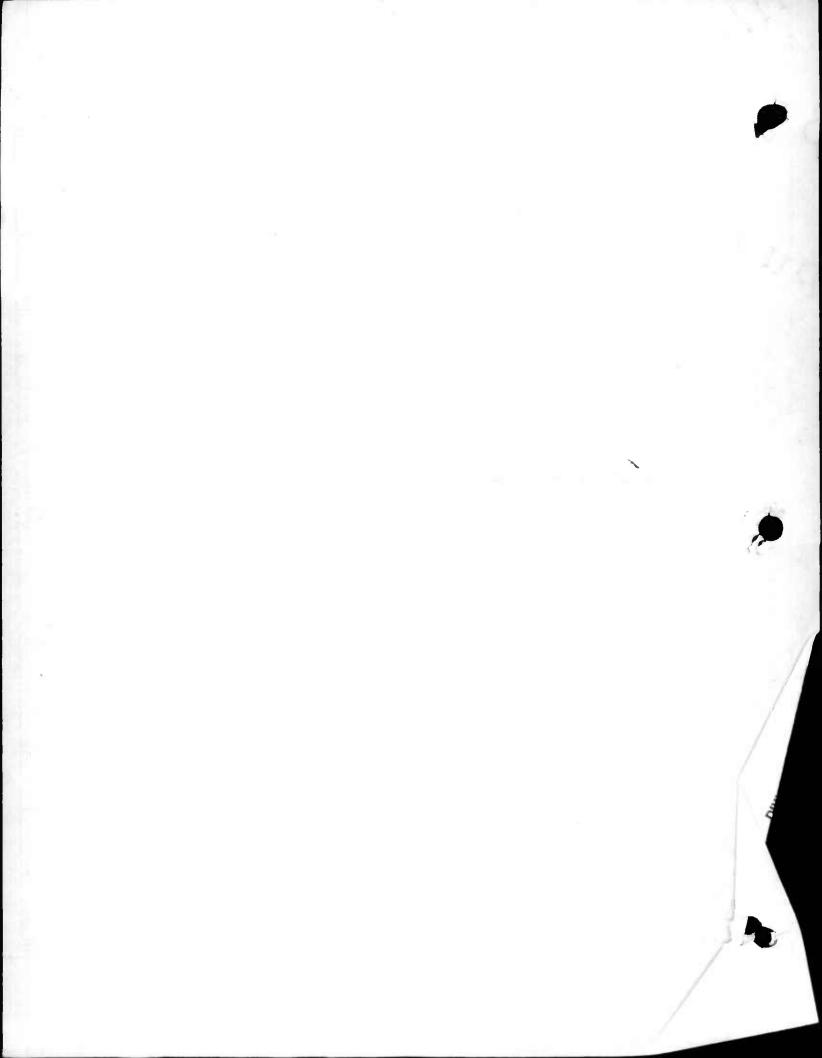
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH Stephen Ernest Davis YEAR iggino 425 6 0 м 95 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign N/A 1 XM 2 - F DAYS 40 YRS 9b. CITY, TOWN OR LOCATION OF 9c. COUNTY OF DEATH DIRECTOR beorges Ctr le 6201905 RESIDENCE OF DECEDENT 100. STATE Maryland 10c. CITY, TOWN OR LOCATION Landover Prince Georges 10d. INSIDE CITY XX YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2818 Red Oak LAne 20785 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 HO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yee, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Bleck, White, atc. 1 Never Married 2 Merried If yee, specify Cube B₹ 3 Widowed 4 Divorced Specify: Black COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 18b. KIND OF BUSINESS/INOUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) L'Shahn Davis BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Numb 2 Betty Liggins 2818 Red Oak Lane, Landover, MD 20785 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State emetery, cremetory or other place)
Harmony Memorial Park 7/22/95 Landover, MD ☐ Donetion 5 ☐ Other (Specify) 21. SIGNATURE OF A RAL SERVICE LICENSES 22. NAME AND ACCRESS OF FACILITY Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham, MD 20706 23. PART /. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, euch as cerdiac or respiratory errest, shock, or heart feliure. Liet only one ceuse on each line. Approximate Interval Between IMMEDIATE CAUSE (Finel Onaet and Daeth Misease or condition_ rematuri reaulting in daeth) DUE TO (OR AS A meele PHYSICIAN: MEDICAL CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, laeding to immediata cause. Enter UNDERLYING CAUSE (Diseesa or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24s. WAS AN AUTOPSY PERFORMED? 1 - YES 2 50 OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO IY UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, term, straet, tectory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner es stated. 2 __ MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, data and place, end due to the ceuse(e) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Deigo 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Prince George

lidon

32. REGISTRAR'S SIGNATURE

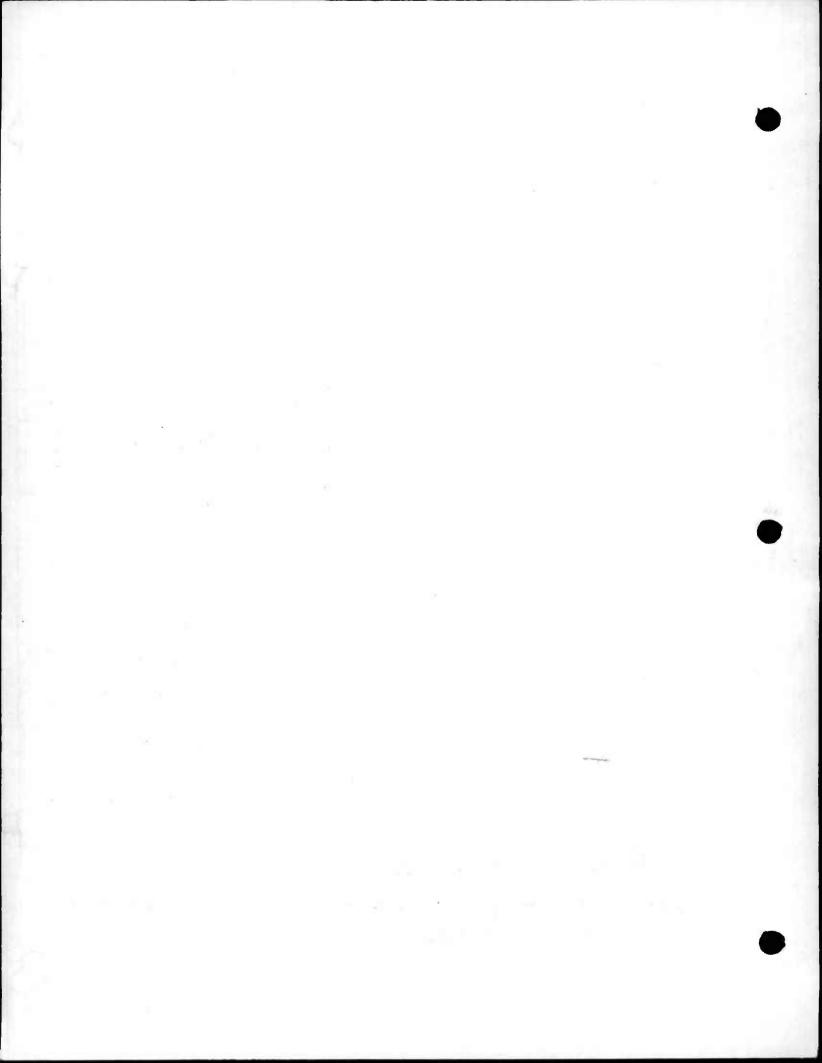
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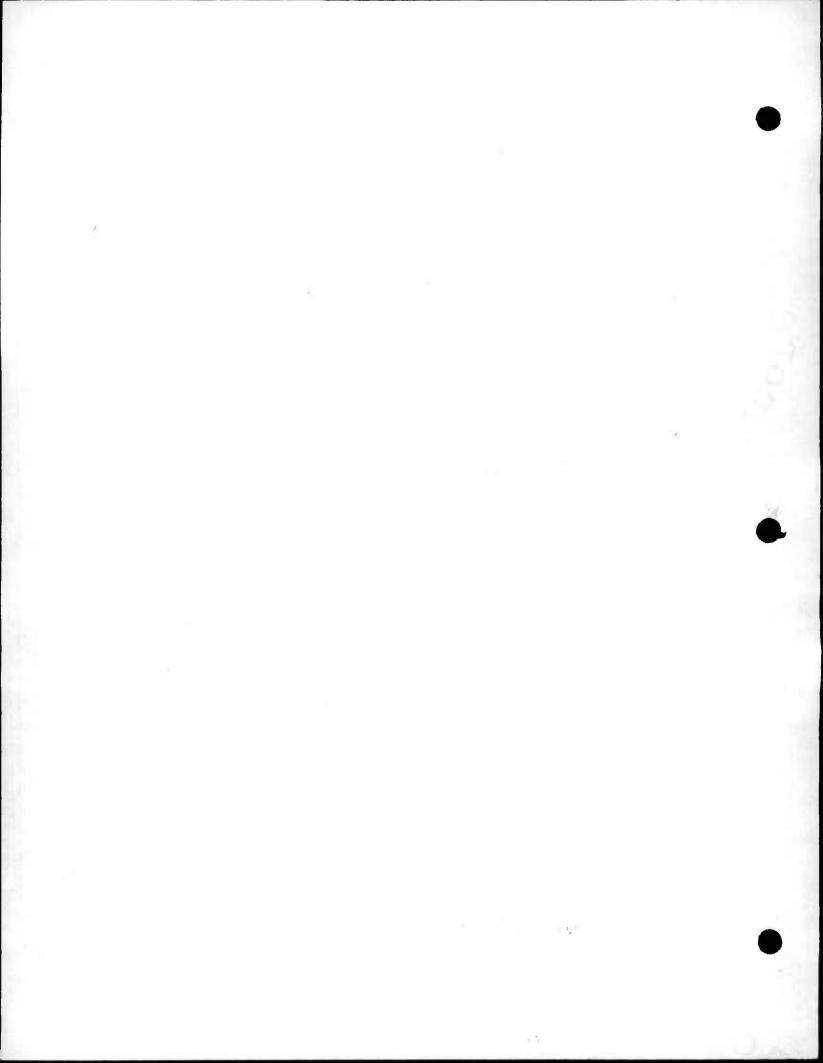
ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-726 8/10/95 t.t

DIVISION OF VITAL RECORDS, P.O. BOX 68760 S BALTIMORE, MARYLAND 21215-0020

	1 - FOR STATE REGISTRAR	STATE OF MARYLANI		TMENT OF I		MENTA	AL HYGIEN				
	DECEDENT'S NAME (First, Middle, Lest) Jon W		Da	rnell		2. DATE MON			9.5	TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER		s. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	E OF BIRTH hth, Day, Year) 7/3/196	R	-	CE (State or Foreign	
OR	9a. FACILITY NAME (If not institution, give street McClean Lane - i				or Location of D ensvill			9c. COUNT	n An		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Anne A	rundel	10c. CIT	Y, TOWN OR LOCA	A STATE OF THE STATE OF				10d	I. INSIDE CITY LIMITS?	
FUNERAL	100. STREET AND NUMBER 313 Buena Vista A	venue	101, ZIP CODE 21012				10g. CITIZEN OF WH			YES 2X NO	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 X Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuben, Maxican, Puerto Rican, etc. 1 YES 2 M NO Specify:						Black, Wh Specify:	American Indian, hita, atc. white	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of Elementery/Secondary (0-12)	ompleted) College (1-4 or 5+)	Give kind of wife. Do NOT us	(GIVe kind of work done during most of working life. Do NOT use retired.)			b. KIND OF BU		TRY		
ш	17. FATHER'S NAME (First, Middle, Last) Jesse Darnell		ruck Di	Transportation 16. MOTHER'S NAME (First, Middle, Maiden Surname) Janice K. Pownall					11		
TO B	19a INFORMANT'S NAME (SparPitel)										
	20a. METHOD OF DISPOSITION 1										
	- Medelhelm	Nacon		Adve Anna	nt Memor polis MD	ial 214	01				
	23. PART I. Enter the disesses, or co ahock, or heart failure. Li IMMEDIATE CAUSE (Finel disease or condition resulting in death)	DROWNING COMPLI	ICATING	CHEST INJ		h as cer	diac or reap	iratory erres		Approximate interval Between Onset and Death	
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL C	PART II. Other significant conditions	g cause given in	Part i.	24a. WAS AN PERFOR	RMED?	AWAI COM OF E	RE AUTOPSY FINDINGS ILABLE PRIOR TO PPLETION OF CAUSE DEATH?				
	DID TOBACCO USE CONTRI			S NO B	UNCERTAI	N			14	YES 2 NO	
PHYSICIAN:		HOSPITAL:	t 3 🗆 DOA	OTHER: 4 Nursing Hon			er (Specify)	at sc			
BY PF	1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year) FOUND 7-15-95 28a. PLACE OF INJURY — AI	7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	P M 1 🗆	DRY AT DRK? YES 2 XXO		ECT DRON		,ED		
ETED	3 ((Suicide s Could not be 4 Homicide determined		281. LOC City	CATION (Street in or Town, State)			Number,				
COMPLETE		AN: To the best of my knowledge On the basis of examination and							ause(s) and	manner as stated.	
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	1. King.	Cen		O.C.M			29d. DATE S ▶ Ju		nth, Day, Year) 6 1995	
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (11 Per	•	eet, Ba	ltin	nore,	Mary	Land	21201	
	JUL 20 1995	32. REGISTRAR'S SIGNATUR									



			FOR STATE REGISTRAR	STATE OF MA	ARYLAND /	DEPARTA	MENT OF	HEALTH AND		YGIENE EG. NO.		
			1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF D		YEAR	3. TIME OF DEATH
			MARY 4. SOCIAL SECURITY NUMBER		DAVIDSO				JULY	17,	1995	9:05 P M
	_		214-05-7411	1 M 2 F	8. AGE (In yrs. las		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B	(Year)	Countr	
3 should			9e. FACILITY NAME (If not institution, give	street and number)	80	98	CITY, TOWN	OR LOCATION OF D	NOV 24		COUNTY OF D	LAND EATH
2		DIRECTOR	SACRED HEART HOS	PITAL			CUMBE	CRLAND		A	LLEGAN	1A
1.000		36	10e. STATE 10b. COUNT			10c. CITY, T	OWN OR LOCA	TION				10d. INSIDE CITY
.E.				EGANY		CUM	BERLAN	ID				t X YES 2 NO
n. ansit pen		FUNERAL	1035 FREDERICK S	TREET			10	21502		10g.	U.S.A.	WHAT COUNTRY?
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Panes 1.2.		B	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT I FORCES? 1 _ IF YES, GIVE WAF	YES 2	MED NO	If yes, s	CENDENT OF HISPA pecify Cuben, Maxic S 2 NO Speci	an, Puario Rican,		14. RACE Black Speci	— American Indien, k, White, etc.
1219 r atten		ETED	15, DECEDENT'S EDU (Specify only highest grade	ICATION 9 completed)	16e. DE	CEDENT'S USI	JAL OCCUPATI	ION ost of working	16b. KIND	OF BUSINES	S/INDUSTRY	
D 2		PE	Elementery/Secondary (0-12)	College (1-4 or 5+)	100			RCULES I	NC. RE	SEARCH	/DEVEL	OPMENT
AN the hos detach	once.	COMPL	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA				
MARYLAND retained by the hospit 5 should be detached	75	BE (GROVER C. SHILL	INGBURG				EDITH M				_
	21	임	190. INFORMANT'S NAME (Type/Print) VIRGINIA L. CHRIS	TOPHER	19	b. MAILING AD 13808	DRESS (Street CARDIN	end Number or Rural AL DRIVE	S.E. C	ty or Town, State CUMBERI	AND MA	ARYLAND
ALTIMORE, death. Page 6 may be funeral director, page	must be		20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rest 4 Donation 5 Other (Specify)	noval from State	20b. PLACE	AND DATE OF D	ISPOSITION (N	ULY 20 1	DATE 995		N — City or To	wn, State IARYLAND
ALTIM death. Page funeral dire	i. examiner		21. SIGNATURE OF FUNERAL SERVICE LI	CEMBEE	1 2 2 1 2			ND ADDRESS OF FA				BIRTBAND
BAL ter death the fund			Pale Z.	Herritt	8			ECATUR S				ARYLAND
Es a	or remova medicai		23. PART I. Enter the diseasea, or ehock, or heert failure.	complications that of	caused tha de	ath. Do not	anter the me	oda of dying, suc	ch ee cerdiac o	or reapiretory	arrest,	Approximata Intervsi Between
1			IMMEDIATE CAUSE (Final disease or condition	21. +1	. 0	H 126.1	0	C	C-1	4.5		Onset and Death
	i, cremation, event, the		resulting in death)	. Idiopatl	OR AS A CONSE	DUENCE OF:	nal su	ilmonas	y tim	0113		2 years.
99 Pu	75	Z	Sequantially list conditions,	b					•			
Cian be	rior to buni traumatic	Ě	if any, leeding to immediata cause. Enter UNDERLYING	DUE TO (O	R AS A CONSEC	DUENCE OF):						
. 2 0	other o	CERTIFICATION	CAUSE (Disease or Injury that initiated avents	C. DUE TO (O	R AS A CONSE	DUENCE OF):						
, P.O eath certi	Mental Hy		resulting in death) LAST	d,								
	ing Me	A I	PART II. Other aignificant condition			eculting in t	ha Underlyin	g ceuse given in	Part I. 24a.	WAS AN AUTOF PERFORMED?	PSY 24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
	shows any	MEDIC	Conjestive hear	at failer	L	_				YES 2 NO	,	COMPLETION OF CAUSE OF DEATH?
	show	Σ.	DID TOBACCO USE CONT	PIRLITE TO CALL	ISE OF DEA	TH VEC		UNCERTAI	N. D.			1 TES 2 NO
VITAL I	State Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			E OF DEATH (Check only one)					
F VIT,	or ite	IXSI	1 - YES 2 NO	HOSPITAL:		DOA 4		ne 5 🗆 Raaldence	6 Other (Spe	cify)		
N OF G PHYSIC er this cer	~ ~	BY PH	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF IN (Month, Day,	IJURY Year)	28b. TIME OF		JURY AT ORK? YES 2 NO	28d. DESCRIBE	E HOW INJURY	OCCURED	
	Ø 60	ETED 8	3 Suicide 6 Could not be determined	28e. PLACE OF I building, etc	INJURY — At ho c. (Specify)	me, ferm, stree	t, fectory, offic	:0	26f. LOCATION City or Tow	(Street end Num n, State)	mber or Rural R	oute Number,
DIV OR A	ē :	٦	29a. CERTIFIER (Check only 1 CERTIFYING PHYS	ICIAN: To the beat of my	y knowledge, de	ath occurred at	the time, date	end place, and dua	to the cause(s)	and menner es	nteted	
TO THE HOSPITAL TO THE FUNERAL	hin 72 NT: M	COMPL	one) 2 MEDICAL EXAMINE									and menner se stated.
물 물		BEO	29b. SIONATURE AND TITLE OF CERTIFIE	ما الم				29c. LICENSE NUI		29d.	DATE SIGNED	(Month, Day, Year)
5 5	IMP De f	2	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE		1 27) (Type, Prin	net)	D33280			JULY	8, 1995
	1		Sucil Cunda	M.D. 62.	5 Kent	- Allow	110#	101 Cum	horlas	JMA	215	402
			31. DATE FILED (Month, Day, Year) JUL 1 9 1995	DE PRECISTINA	S SIGNATURE	dell	11.	J Jull	UNCTIVE!	U, I W	. 0-10	
	L		JOF 1 9 1990	July 10			_					



or attending physician. use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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IENDING PRINCIPAL THE LAW REQUIRES THAT THE DESTRUCTION OF EXECUTED WITHIN 24 HOURS ATTER DEATH. PAGE 6 MAY BE RETAINED BY THE HOSPITAL	uneral director, page 5 should be detached	
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death. F	TOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director	
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FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT	OF HEALTH A	ND MENTA	AL HYGIEN REG. NO.	E			
1. DECEDENT'S NAME (First, Middle, Lest) Rudelph	Didio					TH DA		R G 40 AN		
056-22-6860	1 X M 2 □ F				HRS. 7. DAT	E OF BIRTH 713/28	8. B	RTHPLACE (State or Foreign		
University of MD	Baltimore H	lospital			OF DEATH					
	Worcester	10c. Cf1						10d. INSIDE CITY LIMITS? 1X YES 2 NO		
106 STREET AND NUMBER 106 7th St.				101. ZIP CODE 2 1	842			OF WHAT COUNTRY?		
11. MARITAL STATUS 1 Never Merried 2 Married 3 Nidowed 4 Divorced		ATES	If y	yes, specify Cuban,	Maxican, Puerto	IN? (Specify Yes Rican, atc.)	8	ACE American Indian, black, White, aic. specify: White		
15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	ICATION	18a. DECEDENT'S (Give kind of life. Do NOT u	work done duri se retired.)	CUPATION ving most of working	16					
17. FATHER'S NAME (First, Middle, Last)		Police	eman			Middle, Maiden		nent		
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (S	Street and Number or	Rural Route Nui	mber, City or Town	, State, Zip Code	7		
Laura Didio	200	D. PLACE AND DATE	OF DISPOSITION	ION (Name of						
4 Donation 5 Other (Specify)	E	vergreel	22. NA	AME AND ADDRESS	OF FACILITY	Burbag	ge Fund			
23. PART I. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. SE	A CONSEQUENCE O	not antar th	na moda of dying	, auch as ca	rdiac or respir	atory arrest,	Approximata Intarval Between Onset and Daath		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
PART II. Other significant condition	s contributing to death b	out not resulting	in tha unda	arlying cause give	en in Part I.	PERFORI	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
					TAIN 🔁			1 TES 2 NO		
EXAMINER?	26. PLACE OF DEATH (Check only one) NOSPITAL: 1									
1 TES 2 NO	1 Minpatient 2 - ER/Outp			g trome o 🗆 mano	28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? M 1 YES 2 NO					
1 UPS NO 27. MANNER OF DEATH 1. Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28 JURY M	Bc. INJURY AT WORK? 1 YES 2 N		SCRIBE HOW IN	JURY OCCURED			
1 VES NO 27. MANNER OF DEATH 1. Netural 5 Pending 2 Accident Investigation 3 Suicida 8 Could not be 4 Homicide datarmined	1 Mnpatient 2 ☐ ER/Ouis 28a. DATE OF INJURY	28b. TIM	E OF 28 JURY M	Bc. INJURY AT WORK? 1 YES 2 N	O 28f. LO	CATION (Street ar				
1 VES NO 27. MANNER OF DEATH 1. Natural 5 Pending Investigation 3 Suicida 8 Could not be datarmined 29e. CERTIFIER Check only	28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY	28b. TIM INJ	E OF URY M street, factory, and at the time	Bc. INJURY AT WORK? 1 YES 2 N y, office	O 28f, LO C/h	CATION (Street at or Town, State)	nd Number or Rui	ral Route Number,		
	1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURITY NUMBER 056-22-6860 9a. FACILITY NAME (If not institution, give University of MD RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT MD 10a. STATE 10b. COUNT MD 10a. STREET AND NUMBER 1 0 6 7 th St. 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDU. (Specify only highest grade Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last) I GNAZIO DICIO 19a. INFORMANT'S NAME (Type/Print) Laura Dicio 20a, METHOD OF DISPOSITION 1 M Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify) 21. BIGNATUPE UNEAU SERVICE LI 23. PARTY. Enter the diseases, or shock, or haert failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant condition	1. DECEDENT'S NAME (First, Middle, Lest) 4. SOCIAL SECURITY NUMBER 0.56-22-6860 9a. FACILITY NAME (If not institution, give street and number) University of MD Baltimore FRESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MD 10c. STREET AND NUMBER 106 7th St. 11. MARITAL STATUS 1 Never Merried 2 Married FORCES? 1 YES IF YES, GIVE WAR ORE 1953-55 15. DECEDENT'S EDUCATION Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12. FATHER'S NAME (First, Middle, Lest) I Gnazio Didio 10a. INFORMANT'S NAME (Type/Print) Laura Didio 20a. METHOD OF DISPOSITION 1 Ox Burde 1 2 Cremetion 3 Ramoval from Stata 4 Donaton 5 Other (Specify) 21. BIGNATURE OF UNERS. SERVICE LICENSEE 23. PART I. Enter the diseases, or complications that cause shock, or heart failure. List only ons/cause on a shock, or heart failure.	1. DECEDENT'S NAME (First, Middle, Lest) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birinday) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birinday) 6. AGE (In yrs. last birinday) 9a. FACILITY NAME (If not institution, give street and number) University of MD Baltimore Hospital FIESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MD 10c. CT 10a. STATE 10b. COUNTY MD 10c. CT 10c. CT 10c. CT 10c. CT 10c. STATE 10c. STATE 10c. STATE 10c. STATE 10c. STATE 10c. STATE 10c. STATE 10c. STATE 10c. STATE 10c. STATE 10c. STATE 10c. CT Worcester 10c. CT	1. DECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURITY NUMBER 056-22-6860 9a. FACILITY NAME (If not institution, give street and number) University of MD Baltimore Hospital PRESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MD 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED PORCES? 13. WE PORCES? 13. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12. College (1-4 or 5 +) 13. METHOD OF DISPOSITION 13. METHOD OF DISPOSITION 13. METHOD OF DISPOSITION 13. METHOD OF DISPOSITION 13. METHOD OF DISPOSITION 13. METHOD OF DISPOSITION 13. METHOD OF DISPOSITION 14. Denation is Other (Poperly) 21. SIGNATUSE OF UNEARL SERVICE LICENSEE 22. MARITAL STATUS 20b. PLACE AND DATE OF DISPOSITION 1 A Denation is Other (Poperly) 21. SIGNATUSE OF UNEARL SERVICE LICENSEE 22. Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): CHIEF OF AS A CONSEQUENCE OF): Chief of Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): Chief of Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): Chief of Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): Chief of Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): Chief of Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): Chief of Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): Chief of Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): Chief of Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): Chief of Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): Chief of Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): Chief of Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): Chief of Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): Chief of Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): Chief of Marital College (1-4 or 5 +) DUE TO (OR AS A CONSEQUENCE OF): Chief of Ma	1. DECEDENT'S NAME (First, Mickin, Last) 4. SOCIAL SECURITY NUMBER 0.56-22-6860 1. May 2 F 66 1. May 2 F 66 1. May 2 F 66 1. May 2 F 66 1. May 2 F 66 1. May 2 F 66 1. May 2 F 66 1. May 2 F 66 1. May 2 F 66 1. May 3 FUNDERS 1 FUNDER 1	1. DECEDENT'S NAME (First, Mickin, Last) 4. SOCIAL SECURITY NUMBER 5. SEX 0. 56 - 22 - 6860 1. M 2 F	1. DECEDENT'S NAME (First, Micidis, Last) 1. DECEDENT'S NAME (First	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. 1. DECIDENT'S NAME (FIRE, MASS, Last) 2. DECIDENT'S NAME (FIRE, MASS, Last) 4. SOCAL SECURITY NAMERS SAME (FIRE, MASS, Last) 5. SEX (

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

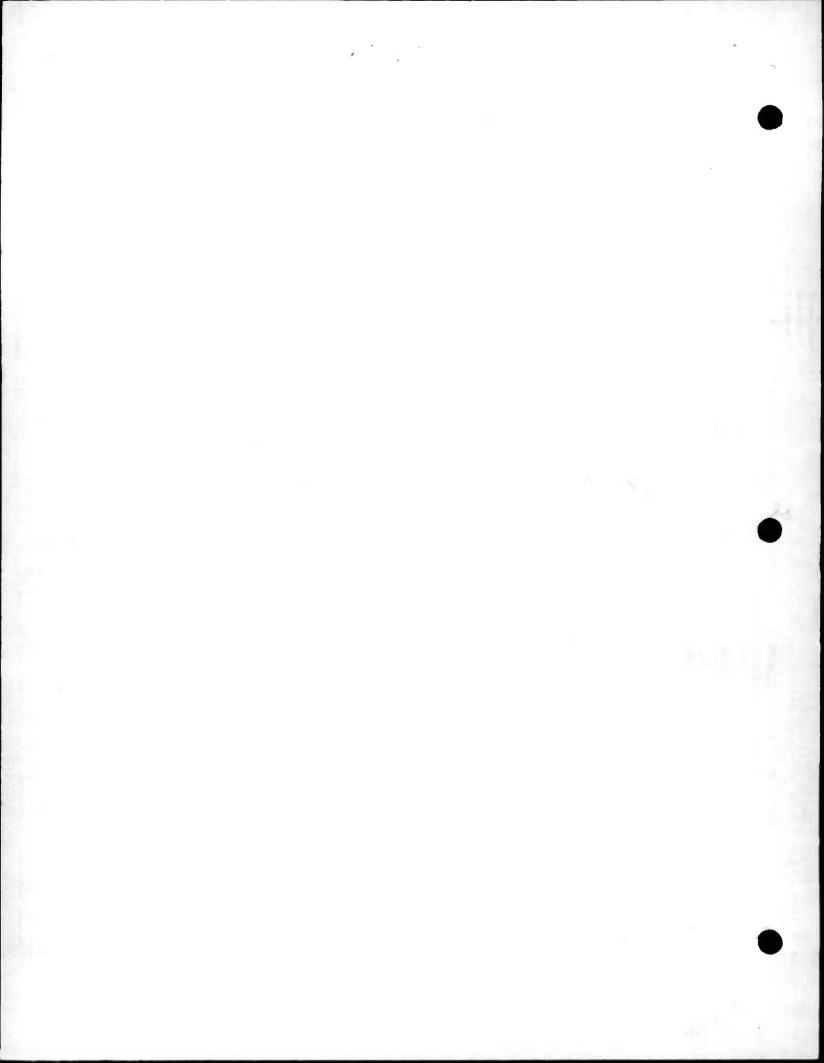
32. REGISTRAR'S SIGNATURE

ARSON

SI. DATE FILED (Month, Day, Year)

JUL 17 1995

GLEENE BALTO MD



Amended #7, 7/17/95, LAL, Fred. Co.

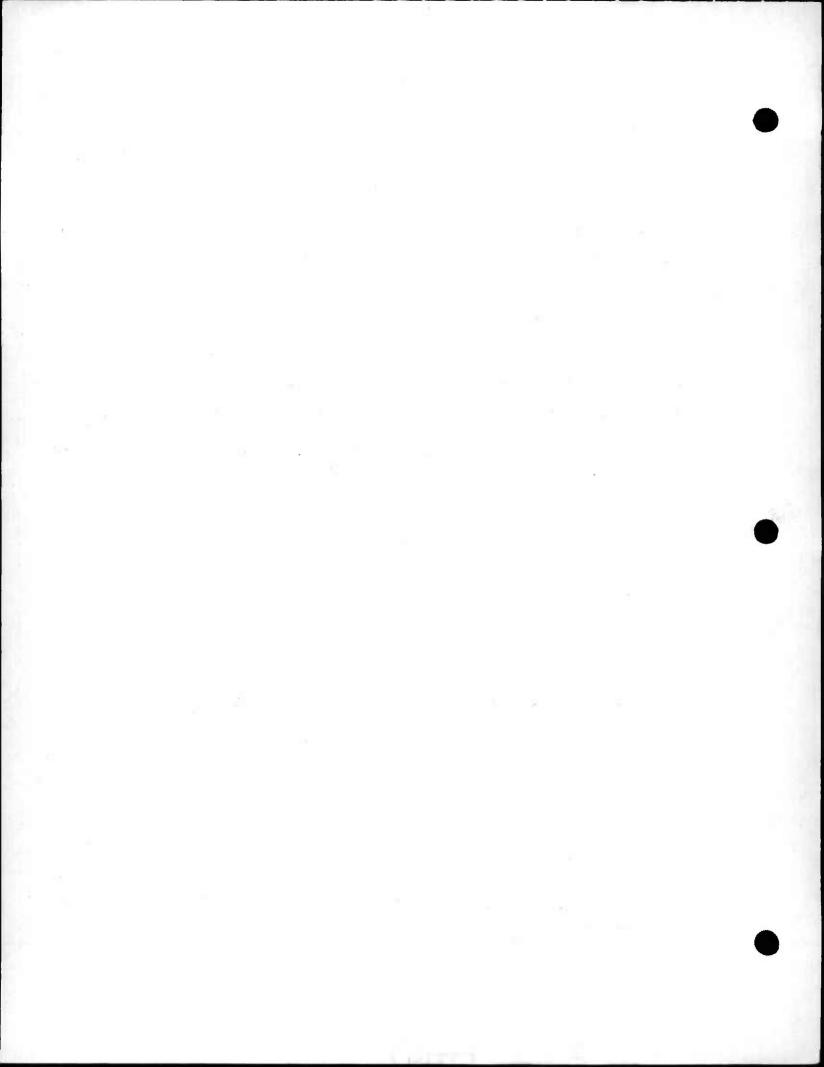
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1 - REGISTRAR			CI	ERTIF	ICATE O	F DEATH		REG. NO.				
I. DECEDENT'S NAME (Firs	t, Middle, Last)						2. DATE	OF DEATH	,	YEAR	3. TIME OF DEATH	
JOHN	EDWAR			[DSO]	J J	R.	50			795	05:00	M
4. SOCIAL SECURITY NUM			AGE (In yrs. las	st birthday)	IF UNDER 1 YEAR		7. DATE	OF BIRTH		8. BIRTHE Country	PLACE (State or Foreign	,
217-44-72		1 💥 M 2 🗆 F	49	YRS.	MONTHS DAY	HOURS MIN.	7-3	th, Day, Year)	46	VIR	GINIA	
9a. FACILITY NAME (If not	Institution, give a	treet and number)		- "	9b. CITY, TOW	N OR LOCATION OF D				NTY OF DE	ATH	
22401 NIC RESIDENCE OF DE 10a. STATE MARYLAND 10a. STREET AND NUMBER 22401 NIC 11. MARITAL STATUS 1. Never Married 2	HOLSO	N FARM R	D.		DICKE	RSON	-		MOI	NTGO	MERY	
10a. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN OR LO	CATION					10d. INSIDE CITY	
MARYLAND	MONT	GOMERY		DIC	CKERSO	N					LIMITS?	
100. STREET AND NUMBER						10f. ZIP CODE			10g. CIT	IZEN OF W	HAT COUNTRY?	
22401 NIC	HOLSO	N FARM R	D.			20842			II. S	S.A.		
11. MARITAL STATUS		12 WAS DECEDENT E	VED IN ILE AD	RMED	13. WAS 0	ECENDENT OF HISPA	ANIC ORIGI	N? (Specify Yea			- American Indian, White, atc.	_
1 Never Married 2 3 Widowed 4 5 Div		FORCES? 1 IF YES, GIVE WAR	OR DATES	NO	If yea,	epecify Cuban, Mexic ES 2 NO Speci	can, Puarto	Rican, atc.)		Specify WHI	<i>(</i> :	
15, DE	CEDENT'S EDU	CATION	16a, DE	ECEDENT'S	USUAL OCCUPA	TION	168	b. KIND OF BUS	INESS/INC			_
15. DE (Specify on Elementary/Secondary (12) 17. FATHER'S NAME (First, 14)	hy highest grade	College (1-4 or 5+)	(G	Give kind of vo. Do NOT us	vork done during	most of working	1.0	u. 14115 O1 500	11123371112	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
12	0-12)	College (I=4 or 5+)	MA	TT C	CARRIE	D		POSTA	T CI	CDVT.	CE	
17. FATHER'S NAME (First, I	Middle, Last)		I IIA	TTD (AILILL	18. MOTHER'S N.				CKVI	CE	_
		ON CD										
19a INFORMANT'S NAME /		ON, SK.			1000500 (0)	DOROT						
DOROTHY D	. ,	ON				27, DIC				208	12	
20a, METHOD OF DISPOSIT	TION				OF DISPOSITION		DAT			City or Tow		_
1 Buriel 2 Cremeti	on 3 Rem	oval from State	cemetery, cre	emetory or o	ther place!		1					
21. SIGNATURE OF FUNERA		ENSEE	I MONO	CAC	CEME	TERY AND ADDRESS OF F	ACILITY	14 BE	ALLS	SVIL	LE, MD.	
> wel		1 01				TON FUN		HOME				
wie	h-c,	ACCO							D.,	BAR	NESVILLI	₹.
IMMEDIATE CAUSE (FI disease Dr condition resulting in deeth) Sequentially liet condit if any, leeding to imme cause. Enter UniDrenty	tiona,	b	R AS A CONSE	OUENCE O	F):	serent	CY	18 N	(3	ን	Interval Betwo	
Sequentially liet condi if any, leeding to imme cause. Enter UNDERLY CAUSE (Diseeas or inj that initieted events resulting in death) LAS	ury	DUE TO (OF	R AS A CONSE	OUENCE O	F):							
	ant condition	s contributing to de	ath but not i	resulting	n the underly	ing cause given in	Part I.	24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDIN	GS
S		orteo						PERFORI			AVAILABLE PRIOR TO COMPLETION OF CAUS	E
		prono		-			-	1 TYES 2	NO		DF DEATH?	
	CO USE	CONTRIBUTE	TO CAL	ISE O	DEATH	YES IT N	0 🖂				1 YES 2 NO	
25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH							(-2)					
EXAMINER?	O MEDICALE	HOSPITAL:			OTHER:	PLACE OF DEATH (C.	neck only o	ne)				\dashv
1 YES 2 NO		I Inpetient 2 E		7		ome Rasidenca	_					
	Pending	28a. OATE OF IN. (Month, Day,		28b. TIM	URY	NJURY AT WORK? YES 2 NO	28d. DE	SCRIBE HOW IN	JURY OC	CURED		
2 Accident	Investigation	28a. PLACE OF II	NJURY — At he	ome farm i			201 1 00	CATION (Street o	and Alexandra	or Over De	A Markey	
3 Suicide 8 Homicide	Could not be determined	building, etc	. (Specify)	orre, rentil, t	Areat, factory, or	ne		CATION (Street as or Town, State)	na Number	or Hunii Ho	oute Number,	
4 Homicide 29a. CERTIFIER (Check only one) 2 MED			_									
(Check only one)		CIAN: To the best of my										
Ž MEC	HCAL EXAMINE	R: On the basis of exem	ination and/or	Investigatio	n, in my opinion	, death occured at the	e time, date	a and placa, and	due to th	na cause(a)	and manner as stated	I.
296. SIGNATURE AND TITLE	E OF CERTIFIES	-	/			29c, LICENSE NU	JMBER		29d. DAT	E SIGNED	(Month, Day, Year)	
		Cos	2			0,46	2 6		▶ 3	019	12,199	
30. NAME AND ADDRESS O	F PERSON WH	O COMPLETED CAUSE	OF DEATH (ITE	M 27) (Type,	Print)							
P. GREGOR			501	WEST	SEVE	NTH STRI	EET	FREDI	ERIC	CK, N	MD. 2170)1
31. DATE FILED (Month, Day,		32. REGISTRANS	SIGNATURE	2						-		

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 curs after death. Page 6 may be retained by the hospital or attending physician. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

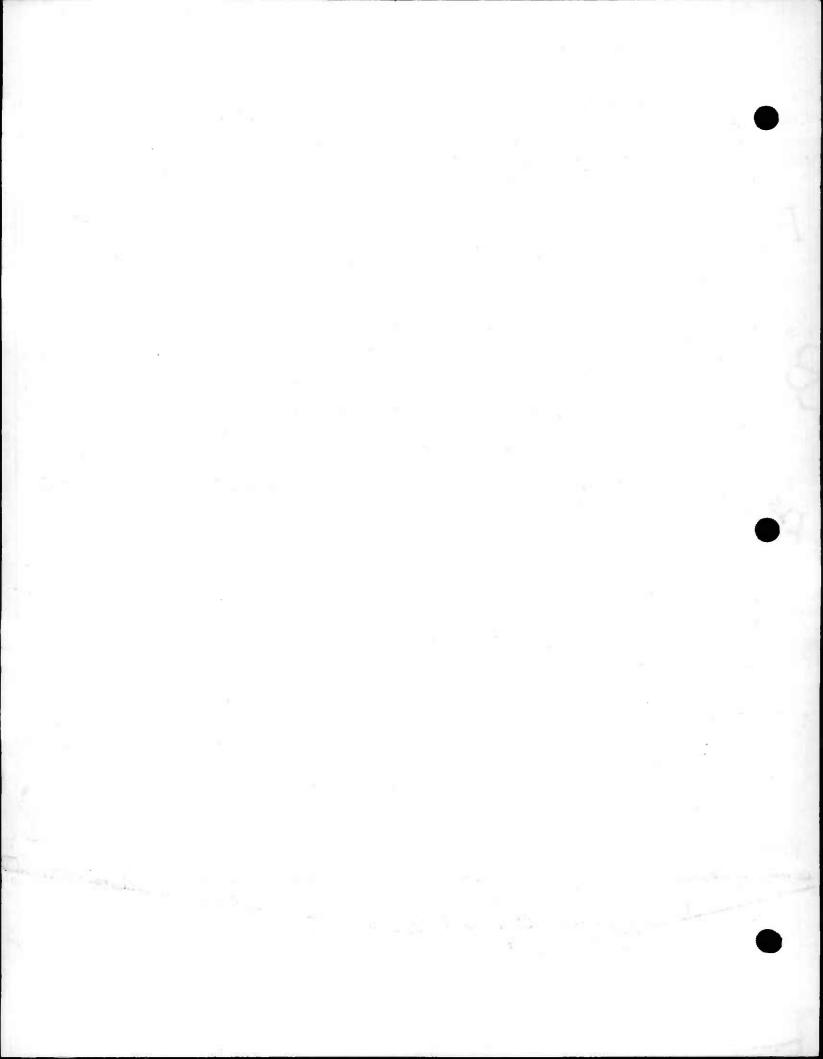
> JUL 1 7 1995 julia d'aveler Rardall



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.
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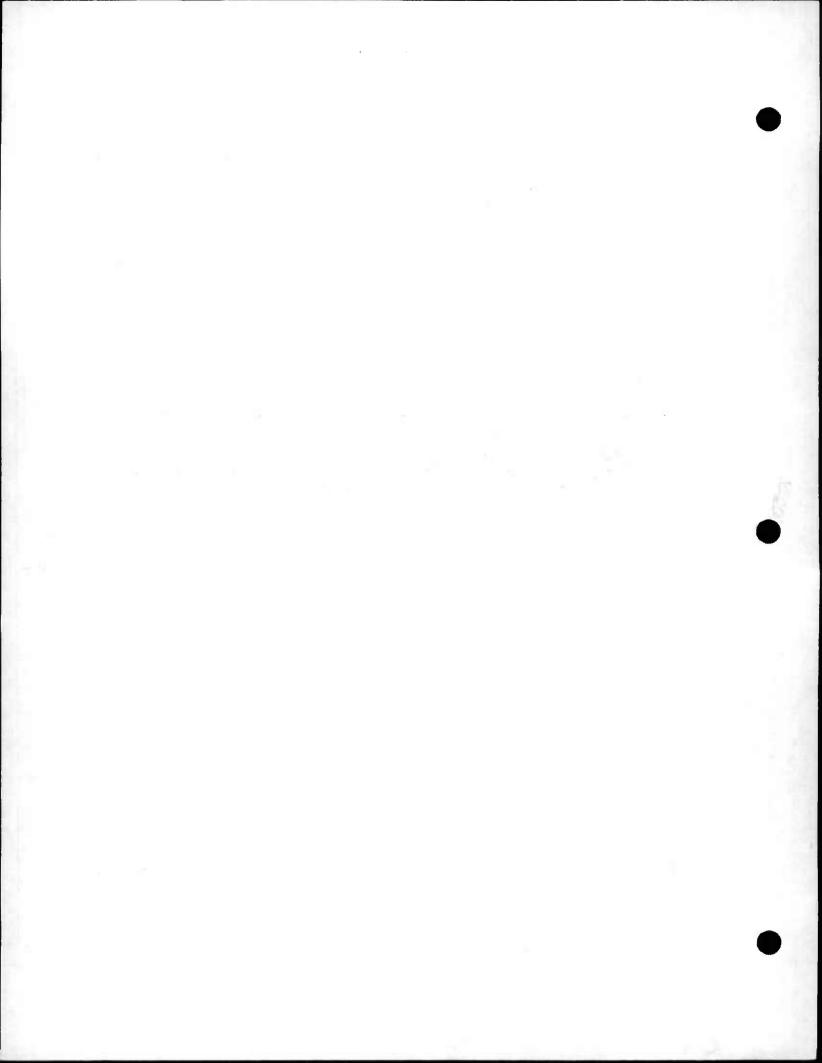
	1 - FOR STATE OF MA	RYLAND / DEPARTME CERTIFICA	ENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	3. TIME OF DEATH
	TENTY 1. DOLL				795 09:28 AM
		MONT	NDER 1 YEAR IF UNDER 24 HRS.	(Month, Dev. Year)	B. BIRTHPLACE (State or Foreign Country)
	197-22-0654 1×120F	65 YRS.		December 1,1929 5	itoverstown, PA
CC	9a. FACILITY NAME (If not Institution, give street and number)	1	CITY, TOWN OR LOCATION OF DE	0.1	TY OF DEATH
1 5	Deaton Specialty Hospital + +	10me	Daltimore	Dal	fimore
DIRECTOR	10a. STATE 10b. COUNTY	10c. CITY, TOV	VN OR LOCATION		10d. INSIDE CITY
	remylvania 10th	1 9	ork		1 YES 2 NO
RAI	100. STREET AND NUMBER		101. ZIP CODE	10g. CITIZI	EN OF WHAT COUNTRY?
BY FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT 8	WED IN II S ADMED	12 WAS DECEMBENT OF HISPAN	IIC ORIGIN? (Specify Yes or No.— 1	3 <i>P</i> 4
1 =	1 Never Married 2 Merried FORCES? 1 FVES GIVE WAR	YES 2 NO	If yes, specify Cuban, Maxica	n, Puarto Rican, atc.)	4. RACE — American Indian, Black, White, etc.
	3 Wildowed 4 Divorced Kore		TES 2 pr NO Specin		white
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USUA (Give kind of work do	one during most of working	16b. KIND OF BUSINESS/INDU	STRY
ة	Elementery/Secondary (0-12) College (1-4 or 5+)	R . Do NOT use retire		Bar P.	
COMI	17. FATHER'S NAME (First, Middle, Last)	Dartend		ME (First, Middle, Maiden Surname)	m
	Henry J. Doll. Sr.		Leah	M. Strausbau	al
TO BE	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDR	RESS (Street and Number or Rural I	910-1	(ode)
	cheryl Rost	140	Rathton R	d. York PA	17403
	20s. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Removal from State	20b. PLACE AND DATE OF DISI competery, crematory or other pla	POSITION (Name of	DATE 20c. LOCATION CI	ty or Town State
5	4 □ Donation 5 □ Other (Specify)	John towne	22. NAME AND ADDRESS OF FA	1 Tork	rA
	Man 0 C 44	-00	John W. Kef	er Funeral Hou	ne Inc.
5	HIOTARY, M	nela	902 Mt. RO	se Ave. York	PA 17403
	23. PART I. Enter tha diseases, or complications that c shock, or heart failure. List only one cause	sused tha death. Do not ar on aach lina.	ntar tha moda of dying, suci	h as cardiac or respiratory arres	Approximate interval Between
	iMMEDIATE CAUSE (Final disesse or condition	catoria fail	ure jarest	and the second s	Onset and Daeth
, and a	resulting in death) s. DUE TO (OI	AS A CONSEQUENCE OF):	ure garrest	1	300000
Z	- Vent	lutor depe	ndent with	Mucheostumy	Bmonths
CERTIFICATION	If sny, laiding to immediata	AS A CONSEQUENCE OF):	b ship our	- (01.	1 1 0 4
	CAUSE (Disease or Injury	AS A CONSEQUENCE OF:	France Cours	SE (Colectimy)	(Eustony) 9 months
Ē	that initiated events resulting in death) LAST	on Caranomi	(4.	1 1	amonths
	d.				
MEDICAL	PART II. Other significant conditions contributing to da		undarlying cause given in	Part i. 24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
Ĭ	- Malnutition - Ilsostemy	- COPD	1	1 DYES 2 NO	COMPLETION OF CAUSE OF DEATH?
Σ		TO DEATH VEC	7 NO 17 INCOME.		1 - YES 2 -NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUS 25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATH (CH		1 1 1	
SIC	EXAMINER? 1 VES 2 NO 1 Inpatient 2 E	OTH		& Cother (Cossibil	
¥	27. MANNER OF DEATH 28s. DATE OF IN. (Month, Day,	URY 26b. TIME OF	28c. INJURY AT	28d. DESCRIBE HOW INJURY OCCU	RED
BY F	1 Netural 5 Pending (month, bay,	6ar) INJURY	WORK?		
	3 Suicide 8 Could not be 28e. PLACE OF III	JURY — At home, ferm, street, (Specify)	factory, office	261. LOCATION (Street and Number or City or Town, State)	Rural Route Number,
COMPLETED					
뒫	(Check only one)				
į į	Z MEDICAL EXAMINER: On the beals of exam	ination and/or investigation, in a	ny opinion, death occured at the	time, data and place, and due to the	cause(a) and manner as stated.
HA H	29th SIGNATURE AND TITLE OF CERTIFIER	VIC - 12/1	29c. LICENSE NUM	BER 29d. DATE S	SIGNED (Month, Day, Year)
0	30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	use / hysici	an 1)411	48	14,22,1995
	FICURAL IN SULLY HI	COLOM	Specials.	Hospital & Ham	10
	31, DATE FILED (Month Day Year)	SIGNATURE,	SYCUUITY	10 spiral of 1011	اک،
	JUL 3 1 1995 July 20 well	or hardell		1	



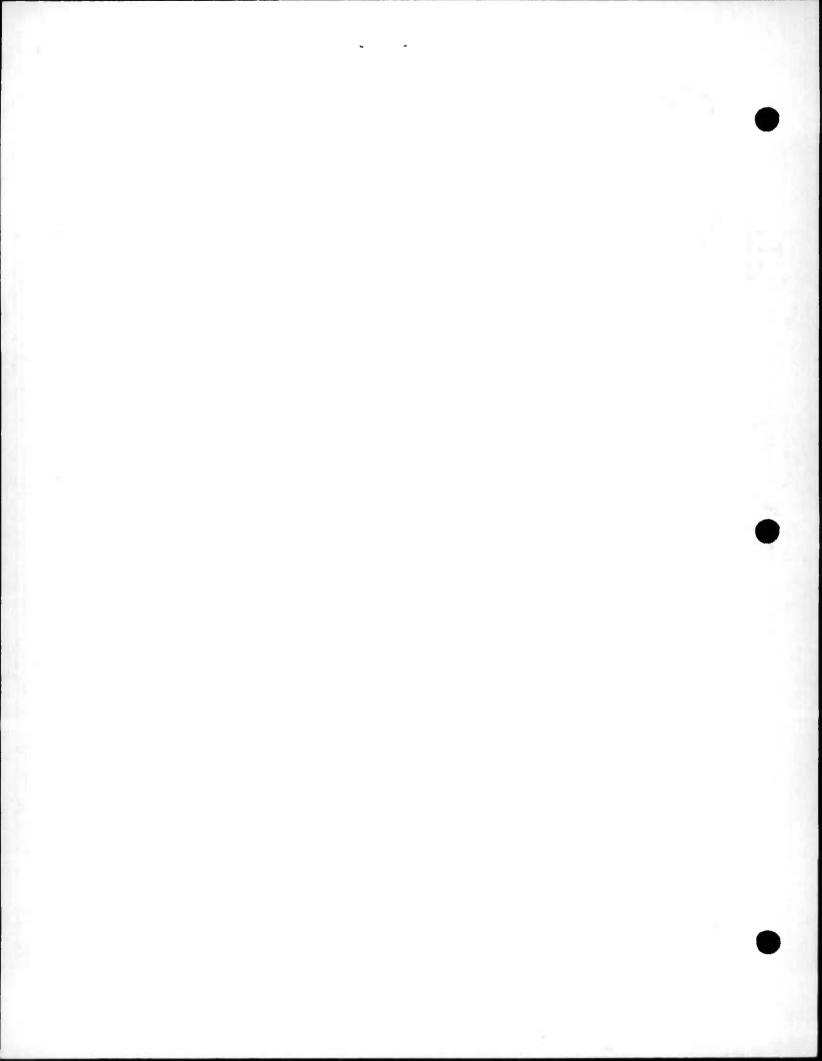
1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

		1. DECEDENT'S NAME (First, Middle, Last)				OAIL	OI DEA	1111	HEG.			
			DECKED						MONTH	DAY	YEAR 3.	TIME OF DEATN
		DELORIS SPASOFF 4. SOCIAL SECURITY NUMBER	DECKER		7.00				JULY 14			1:06 AM M
			5. SEX 6. AG	E (In yrs. last	1200	MONTHS D	EAR IF UNDE AYS HOURS	ER 24 HRS. 7.	(Month, Day, Ye	er)		ACE (State or Foreign
9		232-50-0676		61	YRS.				UG. 16	,1933	PENNS	SYLVANIA
pinous	æ	9e. FACILITY NAME (If not institution, give st						TION OF DEAT	N		TY OF OEAT	
2,	CTO	4405 FORAL PARK R	RD.			BRAI	NIWYDV	E		PRIM	ICE GE	EORGE
	ш	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	1		10c CITY	, TOWN OR L	OCATION				140	d. INSIDE CITY
200	DIR	MARYLAND PRINCE	GEORGE			RANDY						LIMITS?
permit, Pages		10e. STREET AND NUMBER	. GLONGE			IVAIIDTI	10f. ZIP COI	DE		10- 01717	_	YES 2 NO
#5 &	FUNERAL	4405 FLORAL PARK	DU				206			1 -	S.A.	COUNTRY
020 physician. burial-transit	👸	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARI	MED	13 WMG			ORIGIN? (Specif			A
020 physician. burlal-tran		1 Never Married 2 Married	FORCES? 1 YE	ES 2 X N	0	If ye	YES 2 NO	en, Mexican, F	Puerto Rican, etc	÷)	Black, W	American Indian, fhita, etc.
ging a	B√	3 🔀 Widowed 4 🗌 Divorced	II TEG, GIVE VAR OF	OAIES		1 ''	TES 2 (N NC	Specify:			Specify:	rc .
1215-0 r attending use as the	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION	18a, DE0	CEDENT'S	USUAL OCCU	PATION		16b. KIND O	F BUSINESS/INOU		
AND 21; the hospital or detached for u	區	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT use	e retired.)	ng most of work	ang	l			
AND he hospit detached	MP		1	SE	CRET	ARY			EDUC	CATION		
AN the hos detach	00	17. FATHER'S NAME (First, Middle, Last)					18. MO	THER'S NAME	(First, Middle, Mi	siden Sumeme)		
Y L	ш	KANCHO SPASOFF					- 1	WANDA	GUSSY			
MARYLAND 21215-0020 is retained by the hospital or attending physics should be detached for use as the burial notified at once.	TO B	19a. INFORMANT'S NAME (Type/Print)		19b	, MAILING	ADDRESS (St	treet and Numb	er or Rural Roul	e Number, City o	or Town, State, Zip (Code)	
	F	PAUL N. DECKER	· .	Ρ.	0. B	OX 118	36 WAI	LDORF,	MARYL	AND 206-	4	
BALTIMORE, ar death. Page 6 may be the funeral director, page ral.		20a. METHOO OF DISPOSITION 1 X Burlal 2 Cremation 3 Remo	oval from State	20b. PLACE A	ND DATE O	F DISPOSITIO	N (Name of			c. LOCATION — CI		
MOR age 6 m3 director,		4 Donation 5 Other (Specify)		RINI	Y ME		GARD			WALDORF,	MARY	<u> </u>
ALTIN death. Pag funeral di		21, SIGNATURE OF FUNERAL SURVICE LU	House	1	×,			ESS OF FACILI		AC THE		
SALT SALT r death. ee funera al.		BENJAMIN M. M			-	D (ROY	156 W	VAL UOL	ME, INC. MD 206	:04	
Of the Me		23. PART I. Enter the diseases, or o	omplications that caus	sed tha dea	ath. Do n	ot anter the	moda of d	ying, such a	s cardiac or i	respiratory srre	st.	Approximate
		Shock, or heart failure.	List only one cause or	each line.								Interval Between Onset and Death
> = =		disease or condition	Wetast		4	the	luna	i				
		resulting in death)	Metosta DUE TO (OR A Ovaria	S A CONSEO	UENCE OF):	0					Months 14-years
	z		Ovaria	UCA	rcu							147 May
OX 68 e be execut sician and c infor to buri	은	Sequentially list conditions, if any, leading to immediate	OUE TO (OR A	S A CONSEO	UENCE OF):						7
BOX sate be ex hysician a prior to	S	cause. Enter UNDERLYING CAUSE (Disease or injury										
O.O. E	E	that initiated events resulting in death) LAST	OUE TO (OR AS	S A CONSEO	UENCE OF):						
O. Harage	CERTIFICATION	resulting in death) EAST	1									
IDS, F the death y the attend Mental		PART II. Other significant conditions	s contributing to death	but not re	sulting in	n the under	riving cause	given in Par	1 1 24a WA	S AN AUTOPSY	T 24h WE	RE AUTOPSY FINDINGS
CORDS, ries that the de signed by the a leath and Merr ws any injury	DICAL						,,	g		RFORMED?	AVA	AILABLE PRIOR TO MPLETION OF CAUSE
RECOR requires that een signed by of Health an	MEDI								1 🗆 YE	ES 2 -190		DEATH?
RE required to the show		DID TORACCO LISE CONTE	DIDLITE TO CALICE	OF DEAT	ru Vr			CEDTAIN	_		1 (YES 2 -NO
AL RE e law req has been Dept. of	AN	DID TOBACCO USE CONTR	GBUTE TO CAUSE			N (Check only		CERIAIN				
N: The ficate State	PHYSICIAN:	EXAMINER?	HOSPITAL:	0.00		OTHER:			1			
SICIAL Certific the	ΗX	27. MANNER OF DEATH	28a. DATE OF INJUR	and the second	28b. TIME		Nome 5 R		Other (Specify)	OW INJURY OCCU	IDED.	
O 본 특절 👼	9	1 Natural 5 Pending	(Month, Day, Year		INJU	JRY	WORK?		d. DESCRIBE H	DW INJUNT OCCU	HEU	
ONG DING After death	ВУ	2 Accident Investigation 3 Suicide Could not be	28s. PLACE OF INJU	RY — At hon	ne, ferm, et				I DOCATION (S)	treet and Number or	r Divert Dougle	Mumbas
DIVISION OR ATTENDING DIRECTOR: After hours after death	ED	4 Nomicide 8 Could not be determined	building, atc. (S	pecify)		, 100101,			City or Town, S	State)	nurar noute	Number,
DIVISI OR ATTEN DIRECTOR: hours after litem 28 is	COMPLETE	29a. CERTIFIER		100								
3 3 2 5	MP		CIAN: To the best of my kn									
TO THE HOSPITAL TO THE FUNERAL De filed within 72 P	8		R: On the beels of exemina	tion and/or ir	rveatigation	i, in my opini	on, daath occu	ared at the time	e, data and plac	a, and due to the	cause(a) end	d manner as stated.
THE P	BE	296. SIGNATURE AND TITLE OF CERTIFIER					29c. LIC	ENSE NUMBER	R	29d. DATE S		onth, Day, Year)
E 6 3 M	6	Lawrence / total	~ .				De	×66°	10	P +1	17-19	3
		30. NAME AND ADDRESS OF PERSON WHO										
		Edward T. Cull	len, Branc	en Av	e.,	Marl	ow He	eights	, MD			
			32. REGISTRAR'S SH	UNATURE	1.11							
		JUL 1 9 1995	your around	MAN - NAM	MAN .							

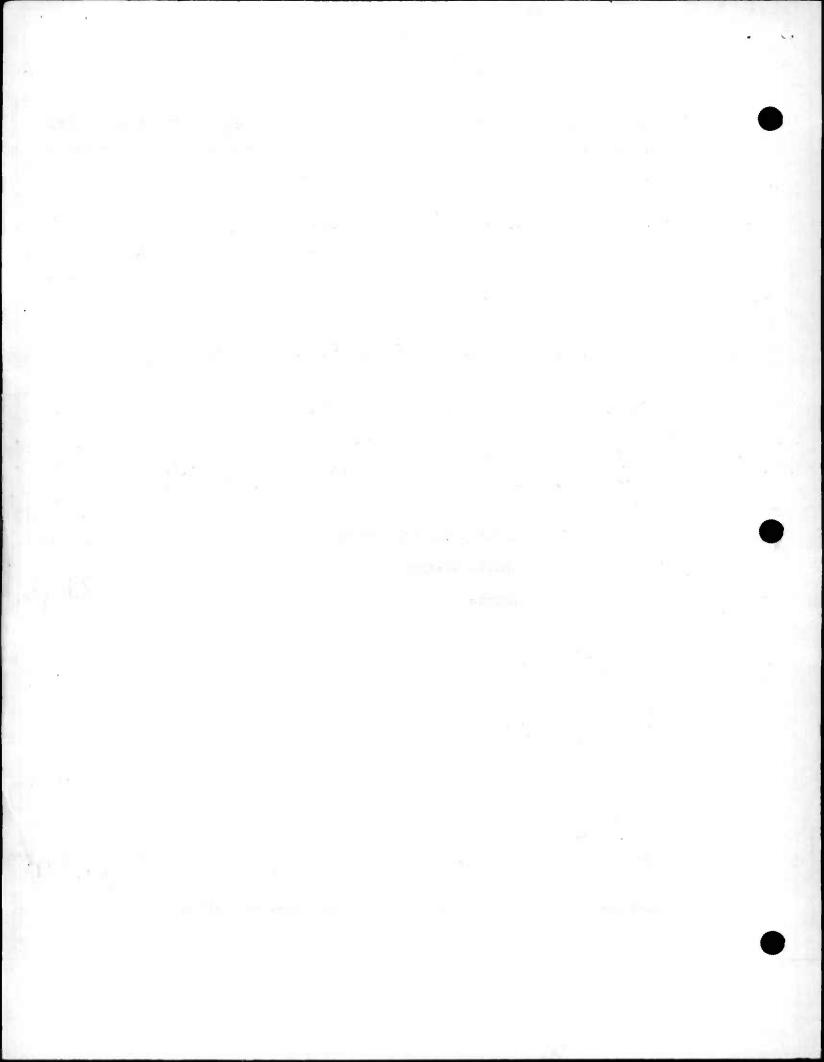


FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JULY 17,1995 JOYCE DICKERSON 4:00AM MARGARET 4. SOCIAL SECURITY NUMBER 501-16-0952 6. AGE (In yrs. lest birthday)
72 yrs. 7. DATE OF BIRTH 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 8/10/1922 1 - M 2 TF ΫD permit. Pages 1. 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR 11855 CHARLES STREET LAPLATA **CHARLES** RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Charles LaPlata 1 TYES 2 NO 10a STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 11855 Charles 20646 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 PNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yee, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried Specify:White BY 1 TYES 2 NO Specify: 3 Widowed 4 Divorced 18e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEOENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 a) 12 Homemaker Home 17. FATHER'S NAME (First, Middle, Last)
Carlton Alonso Johnston 18. MOTHER'S NAME (First, Middle, Meiden Surneme, a Minnie C. Witt Johnston BE notified 190. INFORMANT'S NAME (Type/Print)
Elmo E. Dickerson 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11855 Charles St. LaPlata, MD 20646 9 pe METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of Direct Representation) 20c. LOCATION — City or Town, State must 11 Donation 5 Other (Specify) DATE 7/20/95 Dugspur, VA. 21. SIONATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY AREHART-ECHOLS FUNERAL HOME, INC. M00945 n by the fi removal. 0 Box 567 LaPlata MD 20646 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory erreat, ahock, or heert fellure. List only one cause on each line. filled in by Approximate ö Interval Between Onset and Death IMMEDIATE CAUSE (Final event, the disease or condition_ ZKeim signed by the attending physician and completely Health and Mental Hygiene prior to burial, crematin reaulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68769 other traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate ceuse. Enter UNDERLYING death certificate be CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 6 PART II. Other algorificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO CDMPLETION OF CAUSE OF DEATH? PERFORMED? Desorate (R: ZUIR any 1 TYES 2 NO shows a 1 YES 2 NO t. of P DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 12. UNCERTAIN 1 PHYSICIAN: has b. Dept. DR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h FYAMINER? HOSPITAL: 1 TES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Reeldence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) this c. 28c. INJURY AT 28d. DEŞCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY After t death Investigation 2 Accident 3 Sulcide 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 Is DIRECTOR: COMPLETED 4 Homicide determined Item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. FUNERAL I HOSPITAL -TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: II n and/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFI 29c. LICENSE NUMBER BE 29d. DATE SIGNEO (Month, Day, Year) D-37174 5 10. NAME AND INDORESS OF PERSON LETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7C POST OFFICE ROAD CENNA CENTER WALDORF MD. 20603 SONG CHOL CHON MD. 32. AUGISTRAR'S SIGNATURED Julia DRUBLED Randall 31. DATE FILED (Month, Day, Year) 9 1995

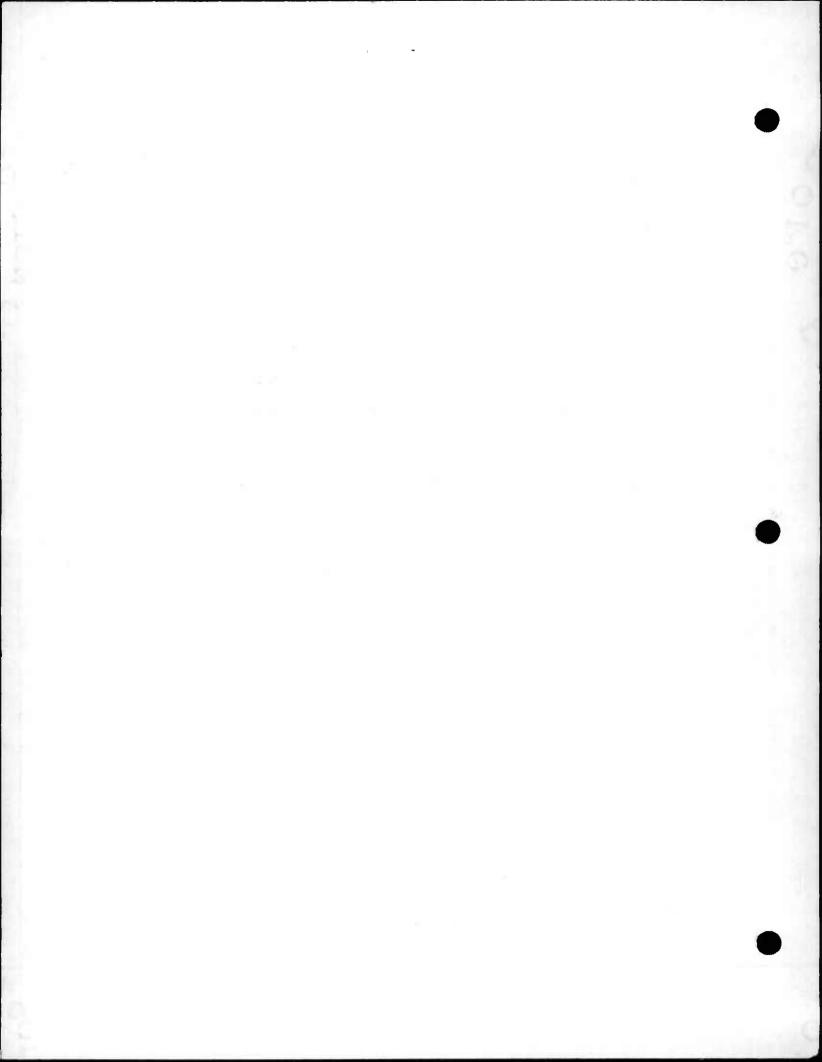


ITAL RECORDS, P.O. BOX 68760	N: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	icate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit
TIMO	h. Page 6	eral directo
BAL	after deat	by the fun
W.	24 hours	filled in
260	ed within	ompletely
X 68	execute	in and o
. BO	ificate by	physicia
P.0	eath cert	attending
RDS	at the d	by the
SECO.	equires th	en signed
FALF	The law r	te has be
	×	ical

		REGISTRAR		CERTIF	ICATE O	F DEATH	REG. NO).	
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY YEAR	3. TIME OF DEATH
	1	STEWART IRVI						1995	1830 M
		4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEA		7. DATE OF BIRTH (Month, Qay, Year)	8. BIFF	THPLACE (State or Foreign ntry)
Pi		223-56-4564	1 XXM 2 □ F	50 YRS.		1155-31	Oct 27, 1	.944	Virginia
3 should	œ	9a. FACILITY NAME (If not institution, give so Dorchester Genera			7.1	n on Location of D bridge	EATN	9c. COUNTY OF	
1. 2. 3	ECTOR	RESIDENCE OF DECEDENT	ii nospitai		Call	Diruge		Doren	ester
Pages	Ë.	10a. STATE 10b. COUNTY	1	10c. CIT	TY, TOWN OR LO	CATION			10d. INSIDE CITY
.e.	DIA.	Maryland Do	orchester		Cambri	dge			LIMITS?
permit.	ERAL	10e. STREET AND NUMBER		· · ·		101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
21215-0020 al or attending physician, for use as the burial-transit	剪	5318 Second Stree	et			21613		US	
20 ysicia	FUN	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? X(X) YES		13. WAS (SECENDENT OF HISPAI specify Cuban, Maxica	NIC ORIGIN? (Specify Year)	s or No- 14, RA	CE — American Indian, ck, Whits, stc.
te p	BY	3 Wildowed 4 XX Divorced	1962 1	DATES	101	ES 2XXNO Specif	y:		white
ttendi	8	15. DECEDENT'S EOU	CATION	16a, DECEDENT'S	USUAL OCCUPA	ATION	16b, KIND OF BU	JSINESS/INDUSTRY	
212 or us	ᆸ	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u	work done during se retired.)	most of working			
spita s	AP	12		Securi	ty Guar	d	Securit	у	
the hospita detached it	COMPL	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maider	Sumame)	
MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the burial- notified at once.	BE (Stewart Dutton				Ma	rgaret Isa	bel Will	iams
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burlat-tran	2	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tov		
		Lillie O. Thomas					idge, Mary		
- CO	İ	20a METNOD OF DISPOSITION 1 M Burisi 2 Cremetion 3 Remo	oval from State 66	b. PLACE AND DATE	OF DISPOSITION ther place)	(Neme of s Cemeter	DATE 20c. LC	DCATION City or	
MOH Page 6 m director,		4 Donation 5 Other (Specify)		aryland		AND ADDRESS OF FA		lurlock,	Maryland
ALTIN death. Pag s funeral di l. examiner		. 10, -0	OTOLE.				1 Home, P.	Α.	
BALT ter death. the funera oval.			mor		700	Locust St	 Cambridg 	ge, Maryl	and 21613
8 3 5 8 8		23. PART I Enter the diseeses, or of the shock, or heart failure.	complications that cause List only ons cause on	ed the death. Do	not enter tha	mode of dying, suc	h as cardiac or resp	iratory arrest,	Approximate interval Between
filled I on, or		IMMEDIATE CAUSE (Final	-W-110 Harmon,						Onset and Death
- 10 =		disease or condition resulting in death)	Cardiopu						1mm.
				A CONSEQUENCE O	F):				
25 170	CERTIFICATION	Sequentially list conditions,	Morbid O	besity A CONSEQUENCE O	EI.				
or t or	¥	if any, leeding to immediate cause. Enter UNDERLYING			•				180045
ertificate no physician ph	트 I	CAUSE (Disease or injury that initiated events	DOE TO (OR AS	A CONSEQUENCE O	r):				04000
ending Hygie	토	resulting in death) LAST	d						,
deal deal deal deal	- 11	PART ii. Other eignificent condition	a contribution to do th	han and an addition					
es that the deargned by the att	MEDICAL	PART II. Other eignincent condition	s contributing to deeth	out not resulting	in the underly	ring ceuse given in		RMED?	b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
	ă						1 TYES	2 🗆 NO	OF DEATH?
		DID TOPACCO LICE CONT	OBLITE TO CALICE	OF DEATH W		[] III.ICEOTA II			1 TES 2 NO
	SICIAN:	DID TOBACCO USE CONTI	GBUTE TO CAUSE C	26. PLACE OF DEA			N L]		
AN: The tificate he State (딣	EXAMINER?	HOSPITAL:		OTHER:				
HYSICIA HYSICIA HISICIA With the Ged, or	PHY	27. MANNER OF DEATN	28a. DATE OF INJURY	28b. TIN	E OF 28c.	ome 5 Residence	28d. DESCRIBE HOW	INJURY OCCURED	
NG PHYS fter this ceath with		1 Selectural 5 Pending Investigation	(Month, Day, Year)	IN.	JURY	WORK? YES 2 NO			
TENDING DR: After there death	BY BY	2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF INJUR	Y At home, ferm,	street, factory, of	ffice	261, LOCATION (Street	and Number or Rura	Route Number,
OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate hi hours after death with the State Ditem 28 is marked, or litem	읟	4 Homicide determined	building, stc. (Spi	всту)			City or Town, State)	
	COMPLET	298. CERTIFIER CERTIFYING PHYSIC	CIAN: To the best of my know	wiedge, death occurr	ed at the time, d	ets and place, and due	to the cause(s) and me	opper as stated	
HOSPITAL FUNERAL Within 72 TANT: If	\$		R: On the basis of sxaminati						(s) and manner as stated.
		296. SIGNATURE AND TITLE OF CERTIFIER				29c, LICENSE NUI			D (Month, Day, Year)
O THE B filed WPOR	B	KIL	and the same	- Andrewson - Andr		D42070		▶ Taga	419 1991
E E 9	2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF D	EATN (ITEM 27) (Type	, Print)	1 = 1= 370		1)17,113
		Lisa Kirven	402 Br	rn Street	Co	mbridge. 1	VID 21612		
ŀ	1	31. DATE FILED (Month, Day, Year)	32. SEGISTRAL'S SIG		Lá.	mur ruse	MD 21613		
		JUL2 0 1999) (And A day of the little of the					



		1 - FOR STATE OF REGISTRAR	MARYLAND C	DEPAR	TMENT OF	HEALTH AND DEATH		IYGIENE REG. NO.			
	à	1. DECEDENT'S NAME (First, Middle, Last) Isabel	R.		Eng.	le	2. DATE OF MONTH July	DAY	YEAR 95	3. TIME OF DEATH 7:10 P	
Pir	8	4. SOCIAL SECURITY NUMBER 218-48-8719 5. SEX 1 M 2 X X	6. AGE (In yrs. Is	YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		27,190	8. BIRTH Countr	PLACE (State or Foreign y) W JERSEY	
, 2, 3 should	стов	99. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL RESIDENCE OF DECEMENT			9b. CITY, TOWN OR LOCATION OF DEATH EASTON				9c. COUNTY OF DEATH TALBOT		
Pages 1,	DIREC	10+. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	ATION				10d. tNStDE CITY	
permit. Pa	AL DIF	MARYLAND TALE 10e. STREET AND NUMBER	OT	0	XFORD	Of. ZIP CODE		100	CITIZEN OF V	LIMITS? 1 YES 2 NO VHAT COUNTRY?	
. S.	1 65	5008 HEL'S HALF ACRE				21654			JSA	THAT GOOM INTO	
5-0020 nding physician. Is the burial-transit	BY FUN	1 Never Merried 2 Merried FORCES?	ENT EVER IN U.S. AI 1 YES 2 X WAR OR DATES	RMED (NO	If yes, s	CENDENT OF HISPA pecify Cuben, Mexic S 2 NO Spec	an, Puerto Ricer	pecify Yes or No n, atc.)	- 14. RACE Black Speci	— American Indian, k, White, etc.	
or afte	ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(C	ECEDENT'S Give kind of v	USUAL OCCUPATI	ION ost of working	D OF BUSINESS	I /tNDUSTRY	WILLE		
D Spital of to	립	Elementery/Secondary (0-12) College (1-4 or 3	5+)			NURSE		MED]	CAL		
KYLAN ed by the hould be detach	COM	17. FATHER'S NAME (First, Middle, Last) HORACE FRANCIS REED				18. MOTHER'S N					
₹ 2 €) BE	19e. INFORMANT'S NAME (Type/Print)	19	Bb. MAILING	ADDRESS (Street	ISABET				AE.	
Pe sage	임	NANCY E. HOWARD 20a. METHOD OF DISPOSITION				5, ROYA					
NOR Page 6 ma director, p		1X Buriet 2 Cremetion 3 Removat from State 4 Donetion 5 Other (Specify)			of disposition (N ther place) EMETER		7-20	OXFOR		wn, State D 21654	
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE			22. NAME A	AM FUNE	ACILITY			3 21034	
S after death. S py the funera removal.			D'CE		1	S. HARE	RISON	ST., E	EASTO	N, MD	
withing hours a pletely filled in by cremation, or rem		23. PART I. Enter the diseases, or complications a shock, or heart failure. List only one of iMMEDIATE CAUSE (Final disease or condition resulting in death)	hat caused tha di auaa on aach iini TO (OR AS A CONSE	vu	in	oda of dying, su	ch as cardiac	or reapiratory	arrast,	Approximata interval Batween Onset and Death	
ECA 6876 sate be executed hysician and com prior to burial, or traumatic ex	ICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c									
rth certificate tending physical Hygiene processes or other t	ERTIFI	that initiated events resulting in death) LAST d.									
at the death by the atter and Mental y injury, o	AL C	PART II. Other significant conditions contributing	to daath but not	reauiting i	n the undariyin	g cause given in	Part i. 24s	. WAS AN AUTOP PERFORMED?	SY 24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
law requires that as been signed by bept, of Health an 23 shows any	MEDIC					-	1	YES 200 NO		COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
N 6 8 0 1	AN:	DID TOBACCO USE CONTRIBUTE TO C				-	N 🗆	_			
SICIAN: The certificate has the State D	SICI/	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO TO Input lent:	26. PLA		H (Check only one) OTHER:						
NG PHYSICIA fer this certificath with the marked, or	PHY	27. MANNER OF DEATH 28e. DATE (Month		28b. TIME	E OF 28c. IN.	JURY AT DRK? YES 2 NO		BE HOW INJURY	OCCURED		
TTENDI TTOR: A after de	TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACE building	OF INJURY — At he g, etc. (Specify)	ome, farm, a			281. LOCATIO City or To	N (Street and Num wn, State)	nber or Rural R	oute Number,	
SPITAL OR A INERAL DIREC (thin 72 hours NT: If item	COMPLETE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of	of my knowledge, de examination end/or	eath occurre	d at the time, date	end place, end due death occured at the	to the cause(s)	end menner es place, end due t	stated. O the ceuse(s)	end menner es stated.	
TO THE HOSPITAL (TO THE FUNERAL OF DE filed within 72 h	TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER 2-3	29d.	7-1	(Month, Day, Year)	
		STEPHEN P. CARNEY, M				AVENIII	E. EAS	TON - N	(ID 21)	601	
		31. DATE FILED (Month, Day, Year)	AR SIGNATURE	all			,			-	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hurist-transit nermit. Pages 1 2 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

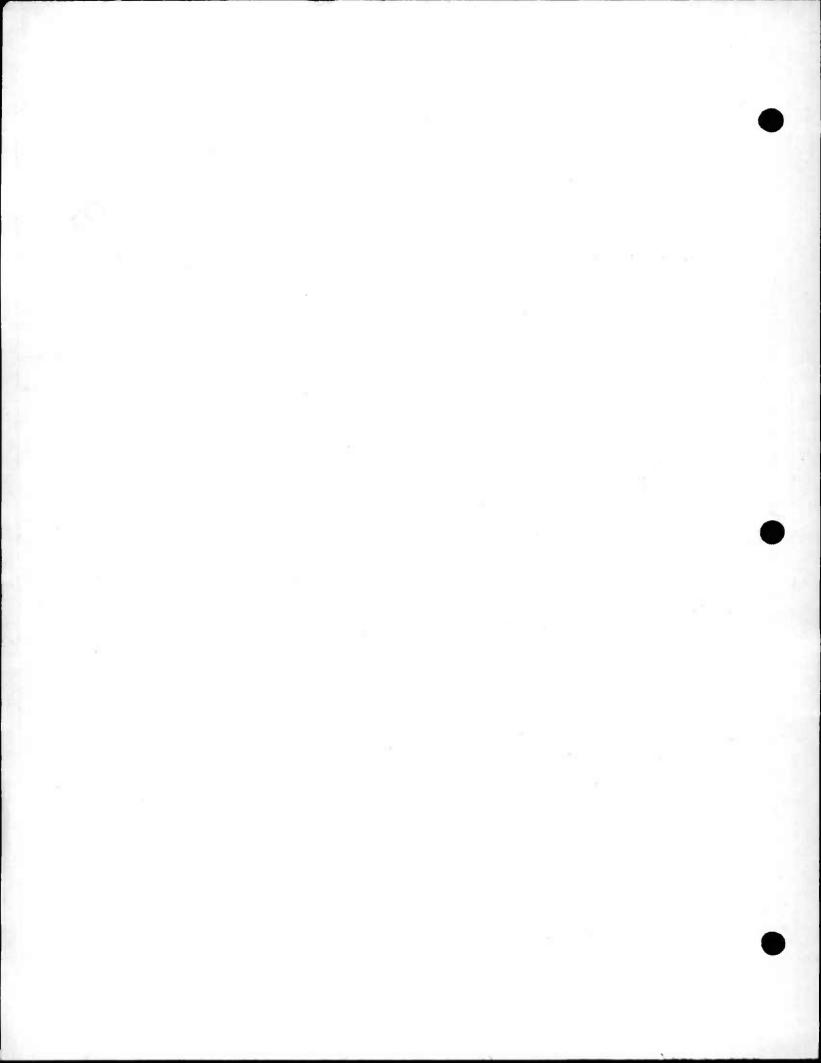
) (0 40114				
	1 - FOR STATE REGISTRAR	STATE OF MARY	YLAND / CE	DEPARTE RTIFE	CATE C	HEALTH AND	MENTAL HYGIE REG. N						
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH	DAY	YEAR 3. TIME OF DEATH				
	Lucie Eli		WORTH			-т-	July 16,		6:40 AM M				
	220-24-7910	1 □ M 2XXF	BE (In yrs. lest	YRS.	MONTHS BAY	B HOURS MIN.	June 24, 1	914	a. BIRTHPLACE (State or Foreign Maryland				
TOR R	90. FACILITY NAME (If not institution, give standard Northampton Manor		ome			n or Location of the lerick	DEATH		ry of oeath erick				
DIRECTOR	10e. STATE 10b. COUNTY	e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION											
FUNERAL	100. STREET AND NUMBER 602 Taney Ave	enue				10f. ZIP CODE 21702			1 Å YES 2 □ NO EN OF WHAT COUNTRY? U.S.A.				
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 XXWIdowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YI IF YES, GIVE WAR OF	ES ZYN		If yes	DECENDENT OF HISPA , specify Cuban, Mexic YES 2XXNO Spec	NIC ORIGIN? (Specify) an, Puerto Rican, etc.) ify:	fea or No 1	14. RACE — American Indien, Black, White, etc. Specify: White				
G	15. DECEDENT'S EOUC (Specify only highest grade of	ATION COMPolished)	18a. OE(CEDENT'S L	SUAL OCCUP	ATION	18b. KIND OF B	USINESS/INDU	STRY				
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		Tomem		most of working	Own 1	Home					
BE CO	17. FATHER'S NAME (First, Middle, Last) Harry	THO	THOMPSON 18. MOTHER'S NAME (First, Middle, Melden Surneme) Elizabeth KETTLE										
TO B	19a. INFORMANT'S NAME (Type/Print) Mrs. Mary E. Groff 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9847 Hall Road, Frederick, Maryland 21701												
	20a METHOD OF DISPOSITION AX Buriel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	val from State	POB. PLACE A	NO DATE OF	F DISPOSITION er place)	ry, July 19,	DATE 20c. I		ty or Town, State Ck, Maryland				
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE			22. NAME	ANO ADDRESS OF F	ACILITY						
	▶ Richard E.	Draf	M0025		106	East Chur	sford P.A ch St., F	rederi	ck. Md. 21701				
	23. PART I. Enter the diseases, or conshock, or heert fellure. L	omplications that caud let only one cause or	ed the dea each line.	ith. Do no	ot enter the	mode of dying, su	ch ae cerdiec or rea	piratory erre	st, Approximate				
	IMMEDIATE CAUSE (Final disease or condition S												
	reaulting in death)	DUE TO (OR A	S A CONSEO	UENCE OF	:				164				
Z	Sequentially list conditions. Sequentially list conditions.												
CERTIFICATION	If any, leeding to immediate	DUE TO (OR A	S A CONSEQ	UENCE OF)					(00)				
15	CAUSE (Disease or Injury	DUE TO (OR A	A CONSECU	HENCE OF					-				
Ē	thet initieted events resulting in death) LAST	50E 10 (0h A.	S A CONSEC	OENCE OF)									
씽	-	•											
N.	PART II. Other algnificant conditions		1	eaulting in	the underly	ring ceuse given in		N AUTOPSY	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO				
MEDICA	- Stepa	sas al v	, a	1	الالا		1 TES	2 NO	COMPLETION OF CAUSE OF DEATH?				
	DID TOPACCO LISE CONTR	IDLITE TO CALIE	OF DEAT	TIL VEC		THE CEPTAL			1 TYES 2 NO				
AN	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CAUSE			Check only o		иЦ	_					
S	EXAMINER? 1 TES 2 NO	HOSPITAL:			OTHER:	loma 5 🗆 Raaldence	2 Oh (0K)						
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF INJUR (Month, Day, Year	Y	28b. TIME		INJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCU	REO				
84	1 Natural 5 Pending 2 Accident Investigation	(MORRI, Day, 18a)	[MJU		YES 2 NO							
8	3 Suicide 8 Could not be 4 Homicide detarmined	28e. PLACE OF INJU building, etc. (S	RY — At hom becify)	ne, farm, ati	eel, factory, o	ffice	281. LOCATION (Street City or Town, State	t and Number or	Rural Route Number,				
COMPLET		IAN: To the best of my knot: On the basis of examine							cause(a) and manner as stated.				
1 1	29b. SIGNATURE AND TITLE OF CERTIFIER				,	29c. LICENSE NU							
) BE	Ü	estin I	411			D 09689			SIGNED (Month, Day, Year) Ly 17, 1995				
121		7						1 000	-J , , , , , , , -				

re, Jr., MD 300 West Ninth Street, Frederick, Md. 21701

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) Type, Print)

Austin Pearre,

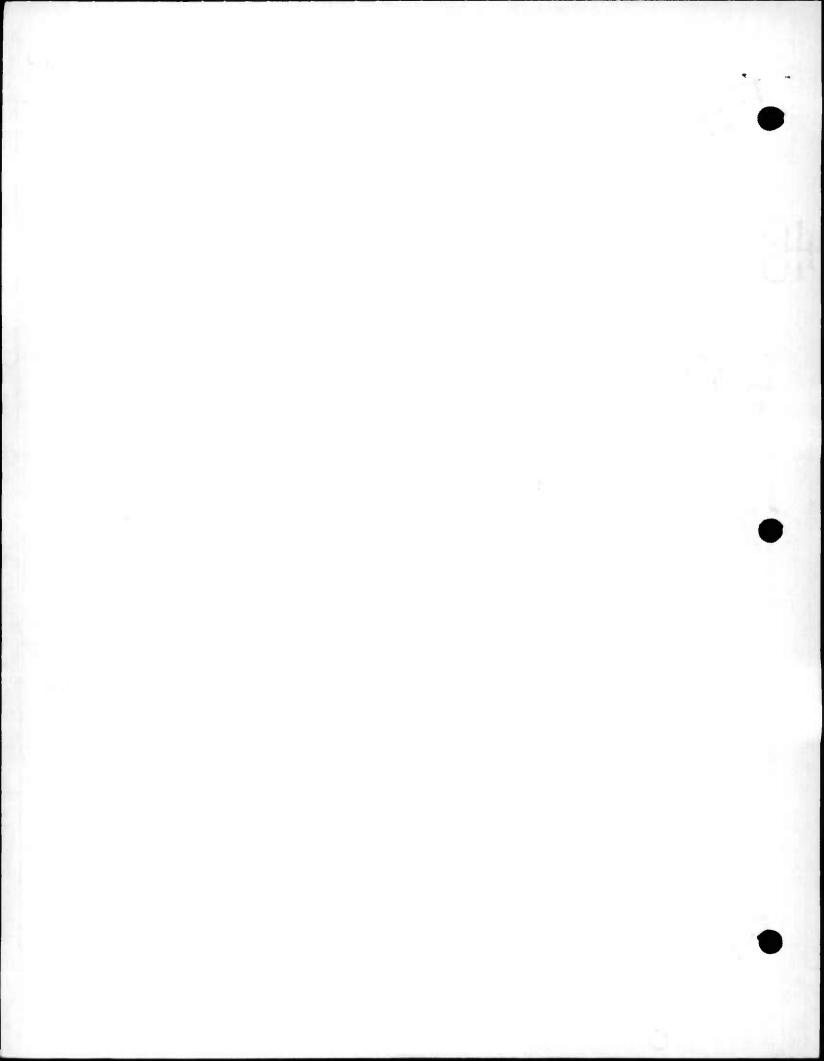
Dr. A. Austin Pea 31. DATE FILED (Month, Day, Year) JUL 1 9 1995



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ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after	OR: After this certificate has been signed by the attending physician and completely filled in by the

								95	23175		
	REGISTRAR	STATE OF MARYLAI	ND / DEPART				GIENE G. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) LARRY D	PALE E	CKAH	PD		2. DATE OF DE	ATH DAY	YEAR	3. TIME OF DEATH		
	215-32-5499	1 M 2 □ F 59		IF UNDER 1 YEAR KONTHS DAYS	F UNDER 24 HRS. HOURS MIN.	Jan.	TH 1936	8. BIRTH Penn	PLACE (State or Foreign		
OR	99. FACILITY NAME (II not institution, give stree Carroll County Ge	EATH		arro							
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	- 1 1	10c. CITY,	TOWN OR LOCAT	ION				10d, INSIDE CITY		
	Maryland Carro		Tai						1 YES 2 NO		
FUNERAL	8 George Stree	≥t		101	21787		10g. CI	U.S.	HAT COUNTRY?		
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	2. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 X NO	If yes, sp	ENDENT OF HISPAI ecify Cuben, Mexice 2 NO Specif	en, Puerto Rican, e	olfy Yee or No — No.)		- American Indian, k, White, etc.		
TEC	15. DECEDENT'S EDUCAT (Specify only highest grade con	mpleted)	6a. DECEDENT'S US (Give kind of wor life. Do NOT use	rk done durina mo	ON sl of working	16b. KIND	OF BUSINESS/IN	IDUSTRY			
COMPLETED	12	College (1-4 or 5 +)	Lineman 1	2000	lass	Ele	ctric U	tilit	гу		
BE CO		ohn Robert Ed							Trostle		
10	196. INFORMANT'S NAME (Type/Print) John Steven Eckard 196. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Mill Avenue, Taneytown, MD 21787										
	20c METHOD OF DISPOSITION 1 © Burlel 2 Cremetton 3 Removel from State 20b. PLACE AND DATE OF DISPOSITION (Name of Control of Place of Plac										
	21. SIGNATURE OF FUNERAL MERVICE LICEN		FUNERAL HOME nneytown, MD 21787								
23. PART I. Enter the diseases, or complications the caused the death. Do not anter the mode of dying, such as cardiac or respiratory a shock, or heart failure. List only one bause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. PYRTUS 36/LVD LLC block disease or condition out to consciousness on the cause of the cause									Approximate interval Between Onset and Daeth		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):										
PHYSICIAN: MEDICAL	PART II. Other significant conditions of	ailure				10°	AS AN AUTOPSY ERFORMED? (ES 2 0 10	246.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
IAN	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH	(Check only one)	UNCERTAIN	N 🗆 📗					
YSIC	1 YES 2 140	OSPITAL: Inpatient 2 ER/Outpatie		THER:	5 🗆 Residence	6 🗆 Other (Specif	y)				
	27. MANNER OF DEATH 1 Deflure 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	286. TIME C		RK?	28d. OEŞCRIBE	HOW INJURY O	CURED			
TED BY	2 Accident Investigation 3 Suicide	28e. PLACE OF INJURY — building, etc. (Specify)	At home, term, stre			281. LOCATION (Street end Number or Rural Route Number, City or Town, State)					
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN DECLE ON MEDICAL EXAMINER: 0	N: To the best of my knowledge On the basis of examination ar							end menner ee stated.		
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO CO	DAMPLETED CAUSE OF DEATH		5 ROG	DZS	Dail	294. DA	7 PINO	Moren. Day 1960 18/95 2/11/8/1/8		
	JULI 9 1995 Julia	32. REGISTRADO SIGNATU	JRE				, , , ,	1			

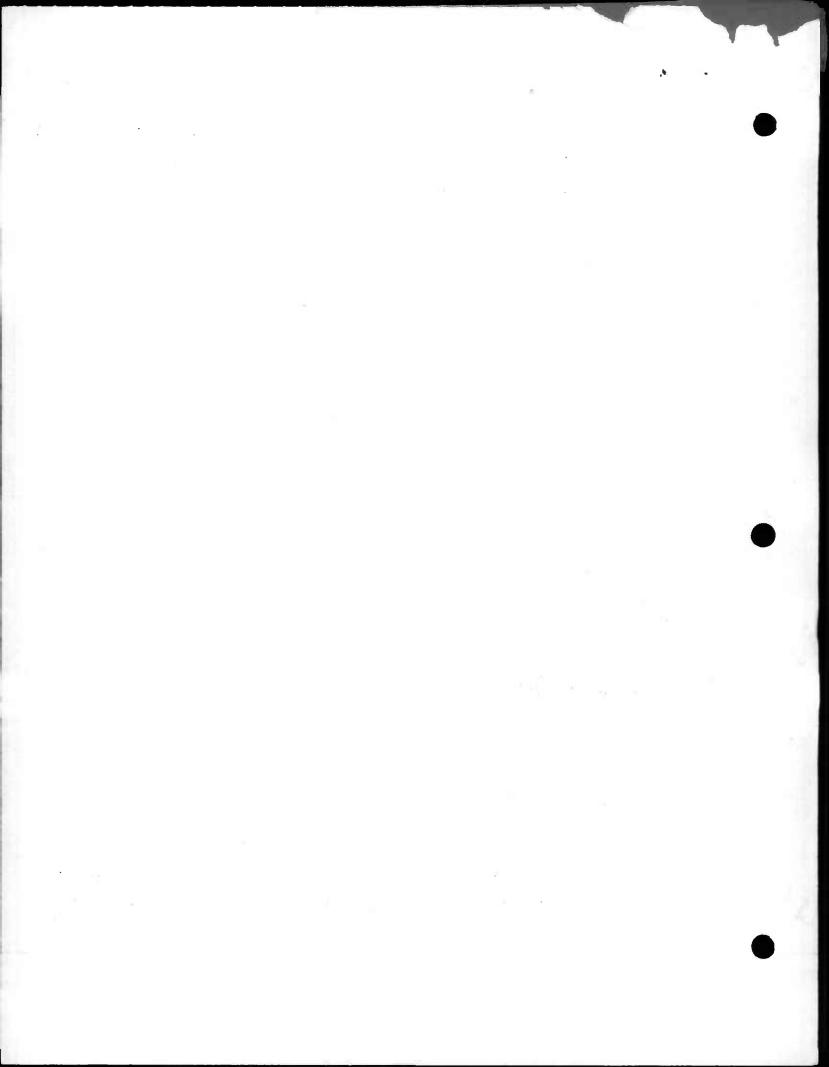


TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the float feath. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Debt. of Health and Mental Hybriene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	_	REGISTRAR				CERTIFIC	CATE O	F DEATH	REG. NO			
		1. DECEDENT'S NAME (First, Mic	ddle, Last)						2. DATE OF DEATH	2		3. TIME OF DEATN
		Lovalia	Ess	om Erb	eck				MONTH 7 D	181	95	6.50 A.
		4. SOCIAL SECURITY NUMBER				last birthday)	F UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BIRTH	101	-	
	- 1	216-16-887	70	1 🗆 M 2 💢 F		M	ONTHS DAY		(Month Day Year)		Country)	
- 1	œ	25 SOCIETY NAME - 80 4/28/1907 Maryland										
		SC COUNTY OF DEATH										
	10H	Carroll Co	unty	General	Hos	pital	Wes	tminste	r	Ca	rrol:	1
	[]	RESIDENCE OF DECED	DENT b. COUNTY	,			TOWN OR LO					
	DIRE	MD		roll							1	IOd. INSIDE CITY LIMITS? 35
			Cal	1011		74	52 CIII 1	nster			1	LIMITS?
	ERAL	10e. STREET AND NUMBER		~ .				10f. ZIP CODE		10g. CIT	TIZEN OF WN	IAT COUNTRY?
		116 Colleg	e Vi	ew Blvd.				21158		Un	ited	States
	FUN	11. MARITAL STATUS		12. WAS DECEDENT E	VER IN U.S.	ARMED	t3. WAS E	ECENDENT OF NISPA	NIC ORIGIN? (Specify Yes	or No-	14. RACE -	- American Indian,
		1 Never Married 2 Mer		FORCES? 1 []	OR DATES	NO		specify Cuben, Mexic ES 2 TVNO Speci	an, Puerto Rican, atc.)		14. RACE — American Indian, Black, White, etc. Specify:	
	BÁ	1 3 X widowed 4 Divorced									Specify.	white
	ED	15. DECEDE (Specify only hig	NT'S EDUC	CATION	18e.	DECEDENT'S US	UAL OCCUP	TION	16b. KIND OF BU	SINESS/IN	DUSTRY	
	<u>.</u>	Elementary/Secondary (0-12)	nost grace	College (1-4 or 5+)	- 1	(Give kind of wor life. Do NOT use i	k done during etired.)	most of working				
	COMPL	?		,		cashi	ar		store			
once	§	17. FATNER'S NAME (First, Middle		casiii		18 MOTNED'S N		Cumanal				
-	BE C	Tr. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surmame) Charles = Essoin Florence Loates										
		19a. INFORMANT'S NAME (Type/	ESSC	401-144-11-11-0-11						tes		
notified	2 ∥		oltz	· m - m					Route Number, City or Tow			1/D
be	1		OIUZ	man					Blvd., We			
ts l		20e. METNOD OF DISPOSITION 1 To Burdal 2 Crametion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 7 / 20 / 95 DATE completery, cramatory or other place) 20c. LOCATION — City or Town, State										
Ē		4 C Donellon 5 Other (Specify) Krider's Church Cemetery Westminster, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE										
=	!	21. SIGNATURE OF FUNERAL SE	RVICE LIC	ENSEE			22. NAME	AND ADDRESS OF FA	CILITY			
medical examiner must		N 4/-11.	,	0	1				neral Hom			
- 8	-	KUTRILIN	11	Fritter - K	wein	34.6	41	<u> 2 Washi</u>	ngton Rd.	W	estm:	inster, M
8	- 1	23. PART I. Enter the disea ahock, or heart	fallura. L	omplicetione that ce list only ona cause	on each li	tlaath. Do not na.	entar the	noda of dying, aud	ch es cardiac or reepi	retory er	rest,	Approximate interval Between
E	ı	IMMEDIATE CAUSE (Final		0 1	- 1		011	-				Onset and Deeth
=	- 1	diseese or condition resulting in death)		Conde	Sta	90	OTT	-				.01
5 5	CERTIFICATION			RO) OT BUD	AS A CONS	EQUENCE OF):			4		0 0	months
2				Ische	un (? Ce	reme	ary he	at d	200	226	months
E	2	Sequentially list conditions if any, leeding to immediate		DUE TO (OR	AS A CONS	EQUENCE OF):		1				+
E	5	cause. Entar UNDERLYING										
i i		CAUSE (Disease or injury that initiated evente DUE TO (OR AS A CONSEQUENCE OF):										
-	ē	reaulting in death) LAST		-								
≥ ₹	3			,								
vs any injury, or other traumatic event, the	ہ	PART II. Other significant of				reculting in	the underly	ing ceuaa given in				ERE AUTOPSY FINDINGS
è C	<u>}</u> ∥	Aspright	an of	homa	9,	H	CVU	AODr	PERFOR			WAILABLE PRIOR TO OMPLETION OF CAUSE
8 1		Rehal 1	45h	BB.	0	Ba	200		1 🗆 YES 2	NO	1	F DEATH?
	Ξ.	DID TOBACCO USE			E OF DE	ATLL VEC		- UNICEPTAL			'	☐ YES 2 →(10
23	E	25. WAS CASE REFERRED TO ME		IBUIE IO CAUS		ACE OF DEATH			иПТ			
r Item 23 s	፤	EXAMINER?		HQSPITAL:		0	THER:	9)				
6	2	1 TYES 2 DO		1 Nnpatient 2 ER				ome 5 - Residence	6 Other (Specify)			
ed, or	5	27. MANNER OF DEATN		28e. DATE OF INJ (Month, Day, Y		28b. TIME C		NJURY AT YORK?	28d. DESCRIBE NOW IF	NJURY OC	CURED	
mar	- 11	1 Natural 5 Pend 2 Accident Inves	sing stigation				M 1	YES 2 NO				
- v		3 Suicide 8 Coul	d not be	28e. PLACE OF IN building, etc.	JURY — At I	home, ferm, atre	et, fectory, of	fice	281. LOCATION (Street a	nd Number	r or Aural Rou	te Number,
82 1	- 11	4 Homicide deter	rmined		, , ,				City or Town, State)			
Item I	J	29e. CERTIFIER 1 7 CERTIFY	NG PHYSIC	TAN: To the heat of my	knowledge	daeth assumed						
= 9		(Check only one) 2 MEDICAL	EXAMINE	: On the best of avant	nation and/	r immediantian	n tree time, de	doeth person of due	to the cause(e) end man	ner ee stat	ted.	
IMPORTANT: II	3					n niversugation, i	n my opinion	, death occured at the	time, date end place, en	d due to th	le Ceuse(e) e	nd manner ee stated.
PORT	ı II	29b. SIGNATURE AND TITLE OF	CERTIFIER	00.0				29c. LICENSE NUI		29d. DAT	E SIGNEDYM	Ionth, Day, Yeer)
₹ 6	, IL	1080	سلع	- The same				1 12.	23015		7/	187405
F		30. NAME AND ADDRESS OF PER	RSON WHO	COMPLETED CAUSE O	F DEATN (IT	EM 27) (Type, Pri	nt)		1 010-			
		DINESH >	. K	ALXRIA	- 3	217	WISH	ING TON	HGT.	WE	>TMIN	201712
		31. DATE FILED (Month, Day, Year)		REGISTRARIS	SIGNATURE	_					<u> </u>	2112)
- 1		JUL 191	uuk	Yalu dhugh	ar las	La II.						·



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								95	2:	317	7
	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF	HEALTH AND	MENTAI	HYGIENE REG. NO.				
- 3	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH	-	3.	TIME OF DEA	ATH
	HAZEL PEARL FI	LAKE				July	I DAY		EAR	3:20	
	4. SOCIAL SECURITY NUMBER		5. SEX 6. AGE (In yrs. last birthday) IF UNDER t YEAR IF UNDER 24 HRS. 7. DATE OF BI							CE (State or i	
- 1	215-36-9867	1□M2XF 84	YRS.	MONTHS DAYS	HOURS MIN.	(Month	Day, Year)		Country)		
	9a. FACILITY NAME (If not institution, give st			9b. CITY, TOWN	OR LOCATION OF (DEATH	1	9c. COUNTY			_
S.	CUMBERLAND NU	RSING HOME		CUMB	ERLAND			Λ1.1	EGAN	IV	
5	RESIDENCE OF DECEDENT							ALL	LUAN		
DIRECTOR				Y, TOWN OR LOCA					100	I. INSIDE CIT LIMITS?	Υ
	MARYLAND ALL 100. STREET AND NUMBER	EGANY	C	UMBERL.						YES 2	
FUNERAL	- In the Control of the Indian	/ CTDEET		10	of. ZIP CODE			10g. CITIZEN			
N.	1823 FREDERICE	12. WAS DECEDENT EVER IN U			21502				S.A.		
3	1 Never Married 2 Married	FONCES? 1 YES	2 V NO	If yes, s	CENDENT OF HISPA pecify Cuben, Mexic	ANIC ORIGIN an, Puerto F	? (Specify Yea : lican, etc.)	or No 14.	RACE Black, WI	American Inc hite, atc.	ilan,
ВУ	3 (X) Widowed 4 Divorced	IF YES, GIVE WAR OR DATE	ES	1 TYE	S 2 NO Speci	tly:			Specify:	WHIT	Ε
8	15. DECEDENT'S EDUC	CATION 1	6a. DECEDENT'S	USUAL OCCUPATI	ION	18b.	KIND OF BUSI	NESS/INDUST	RY		
Ē	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)		vork done during m se retired.)	ost of working	- 1					
AP.	6		HOME	MAKER			HOME				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N						
BE (AMOS ELWOOD HU	JFFMAN			NELLI	E VI	RGINI.	A RIC	E		
6	19a. INFORMANT'S NAME (Type/Print)		t9b. MAILING	ADDRESS (Street	and Number or Rural	Route Numb	er, City or Town,	State, Zip Co	de)		
-	AMOS HUFFMAN		116	WEMPE	DRIVE	- CU	MBERL	AND,	MD	2150)2
	20s. METHOD OF DISPOSITION t	val from State 20b.Pl	LACE AND DATE	Pher place L	lame of	DATE	20c. LOC				
	4 Donatton 5 Other (Specify)		EASANT	GROVE	CEM. 7	119/4	5 CU	MBERL	AND	, MD	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		GFOR	NO ADDRESS OF FA	IIRCH	FUNE	RAI H	OME	P /	1
	Grand 9),	unchurch		202	ND ADDRESS OF FA GE-UPCH GREENE	ST.,	CUMBE	RLAND	MD	2150)2
	23. PART I. Enter the diseases, or c	omplications that caused to	ha desth. Do n	ot anter the me	ode of dylng, suc	ch as card	lac or respin	ntory srreat		Approxin	
	shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final										Between Id Death
	disease or condition resulting in death)	Coronary	Artery	Dispa	20					5 vc	2200
	Tooling it would	DUE TO (OR AS A C	ONSEQUENCE OF	7:	3 C					2 46	ears
Z		A							İ		
ERTIFICATION	Sequentisily list conditions, if any, leading to immediate	DUE TO (OR AS A CO	ONSEQUENCE OF	Ŋ:							
2	CAUSE (Disease or Injury	No									
	that initiated events resulting in desth) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF	ገ):							
SE		4									
	PART II. Other significant conditions	contributing to death but	not resulting i	n tha underlyin	g cause given in	Part I.	24s. WAS AN A		24b. WEF	RE AUTOPSY I	FINDINGS
MEDICAL							PERFORM			RABLE PRIOF	
밀							1 TES 2	V) NO		DEATH?	NO
-	DID TOBACCO USE CONTR	BUTE TO CAUSE OF	DEATH YE	S II NO I	UNCERTAI	NU			' '	YES 2	NO
X	25. WAS CASE REFERRED TO MEDICAL	26.		H (Check only one)							
S	EXAMINER? 1 YES 2 X NO	HOSPITAL: 1 Inpetient 2 ER/Outpetie	ent 3 🗆 DOA	OTHER:	ne 5 🗆 Rasidence	6 ☐ Other	(Specify)			-	
PHYSICIAN:	27, MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	286. TIMI	E OF 28c. tN.	JURY AT		CRIBE HOW IN	JURY OCCUR	EO		
BY	1 Netural 5 Pending 2 Accident Investigation	(moral, bay, roar)	1145		YES 2 NO						
	3 Suicide 8 Could not be	28a. PLACE OF INJURY — building, atc. (Specify)	At home, farm, s	treet, factory, offic	20	261, LOCA	TION (Street an	d Number or F	lural Route	Number,	
ETE	4 Homicide determined					Jany 0	. comit, Galley				
COMPLETED	29a. CERTIFIER (Check only) 1 (X CERTIFYING PHYSIC	CIAN: To the best of my knowled	ge, death occurre	d at the time, date	and place, and due	a to the caus	e(a) and mann	er as stated.			
ĕ		R: On the basis of examination as							use(s) and	manner as	stated.
	29b. SIGNATURE AND TITLE OF CERTIFIED	10. 1			29c. LICENSE NU	MBER		29d. DATE SI	ONED (Mor	ith, Day, Year	
8		- Maria Tan			D2220	20		h 2 2		0 10	

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Sunil K. Gupta, M.D. - 625 Kent Avenue-Cumberland, MD 21502

29c. LICENSE NUMBER D33280

31. DATE FILED (Month, Day, Year)

29d. DATE SIGNED (Month, Day, Year)

July 18,1995

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing more start death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

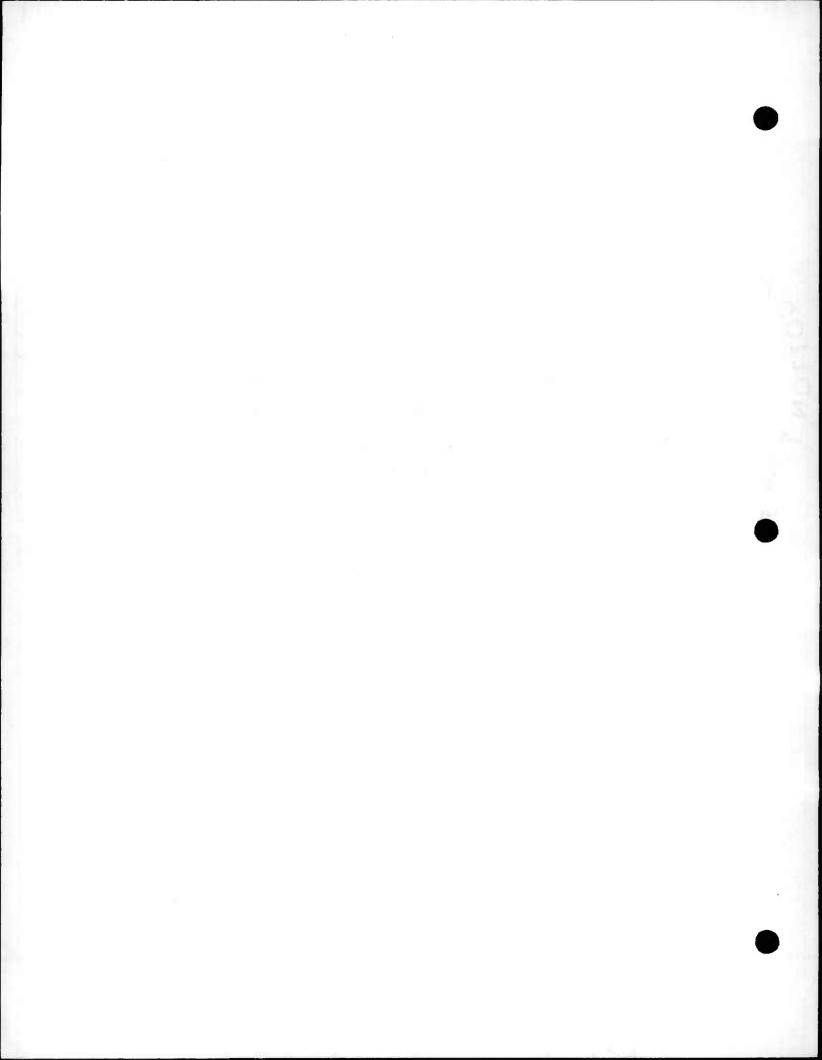
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARTLAND.

Thours after death, Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1	FOR STATE REGISTRAR
	1. DECEDENT'S NAME (First, I
н	

	NEGIO ITAN			- CE	HILL	ICAL	- UF	DEA	111	RE	EG. NO.			
	1. DECEDENT'S NAME (First,									2. DATE OF D	EATH DA	Y	YEAR	3. TIME OF DEATH
	RAYMOND 4. SOCIAL SECURITY NUMB	ARTH		AGE (In vrs. leat						JULY		199		8:45 PM M
	578-30-77		M 2 □ F	85	YRS.	IF UNDER	DAYS	IF UNDER	MIN.	7. DATE OF BI (Month, Day, NOV. 5	Year)		Countr	• •
	9s. FACILITY NAME (If not institution, give atreet and number)						, TOWN	OR LOCATE	ON OF OE	ATH	1,13		NTY OF D	RYLAND
O.	4072 MAIN ST.					7	'RAI	PPE					TALI	вот
ដ្ឋា	10a, STATE	10c CIT	Y, TOWN C	DR LOCAT	TION									
DIRECTOR	MARYLAND		TRAI						10d. INSIDE CITY LIMITS? THYSES 2 NO					
FUNERAL	100. STREET AND NUMBER 4072 MAIN	ST.					101	f. ZIP CODI	673			10g. CITI	ZEN OF V	WHAT COUNTRY?
3	11. MARITAL STATUS	12	2. WAS DECEDENT E	VER IN U.S. ARI	MED	13.	WAS DEC	CENDENT C	F HISPAN	IC ORIGIN? (Sp	ecity Vee	or No.	14. RACE	- American Indian
B≺	1 Never Married XXX 3 Wildowed 4 Divor		FORCES? 1 T		0		If yes, sp	2 XNO	n, Mexicer	n, Puerto Rican,	etc.)			E — American Indian, k, White, atc.
	15. DECI (Specify only	EDENT'S EDUCAT	TION Tripleted)	16a. DEC	EDENT'S	USUAL O	CCUPATIO	ON of working	97	16b. KIN0	OF BUS	INESS/IND	USTRY	
Elementary/Secondary (0-12) College (1-4 or 5+) Iffe. Do NOT use retired.)												ME I) T CII	RIBUTER
MO	17. FATHER'S NAME (First, Mi	ddle, Last)		On	MIM	OLI	il(A)	1	IFR'S NAI	WE (First, Middle,			ופדט	KIBUTER
BE C	RAYMOND H	. FOWI	LER							E BOW		Juli laine)		
198. INFORMANT'S NAME (Type/Print) RALPH B. FOWLER 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4078 MAIN ST., TRAPPE, MD 21673														
											_			
	20e. METHOD OF DISPOSITION XIX Burlel 2 Cremetto	n 3 🗆 Remova	i from State	20b. PLACE A	NDDATEC	E DISPOS	ITION /Na	eme of		DATE	20c. LOC	ATION —	City or To	
	XXBurlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) WOODLAWN MEMORIAL PARK 7-8 EASTON, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
	** N.E. Newnau Funeral springer December 122. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD													
	23. PART I. Enter the die	seesea, or com	plicetions that c	nused the des	sth. Do n	ot anter	tha mo	de of dyl	ng, auch	an cardiac o	or reapir	etory arr	est,	Approximata
	IMMEDIATE CAUSE (Fine	ert fallure. Lis	t only one cause	on each line.										Interval Between Onset and Death
	disease or condition resulting in death)	+ .	Bila	foral	(MAR	en	0.	ho	brone	ho	InOna	MIA	
	DUE TO (OR AS A CONSEQUENCE OF): 2 rospin city tailure 2thalla													
S	IMMEDIATE CAUSE (Final disease or condition resulting in death) B. a for all lawer lake bronch sprenuma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate													
CERTIFICATION	If any, leading to immed ceuse. Enter UNDERLYIN	lata	O CO	AS A CONSEQ	UENCE OF	7):			U					
윤	CAUSE (Disease or Injur		DUE TO DE	AS A CONSEO	JENCE OF):								inunth
E	resulting in death) LAST	100				,								i l
		u												
MEDICAL	PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE													
ă	alun	al frie	mul	auson	an	_0	ach	med	Mo	<u> </u>	YES \$	NO NO		COMPLETION OF CAUSE OF DEATH?
ž						15/				_	ι			1 _ YES 2 _ NO
A N	DID TOBACCO US		UTE TO CAUS				40 E	UNC	ERTAIN					
PHYSICIAN	25. WAS CASE REFERRED TO EXAMINER?	Н	OSPITAL:	26. PLACE		OTHER								
¥.	1 YES 2 NO	1	28a. DATE OF INJ						eldence 8	Other (Spec				
	Netural 5 P		(Month, Day,		28b, TIME			PK? YES 2	1 400	28d. DESCRIBE	HOW IN	JURY OCC	URED	
B	3 Suiside	rvestigation	28e. PLACE OF IN	JURY — At hom	a farm e	tract facts				201 LOCATION	(Charles on	and Advanced as a		
COMPLETED		could not be etermined	building, etc.	(Specify)			, one	-		281. LOCATION City or Town	n, State)	id Number	or Hurel H	oute Number,
2 1	290. CERTIFIER CERTIFIER	FYING PHYSICIAL	N: To the best of my	knowledge, des	th occurre	d at the ti	me, date	and place,	and due t	o the cause(s)	end menr	er as state	d.	
296. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as as									and manner as stated.					
	290 GIGHRTURE AND TITLE	_	01	7			1		NSE NUMI		-			(Month, Day, Year)
3 BE	July 101	Lai	wort	-W	/			D02				> -	7/7	195
2	30. NAME AND ADDRESS OF ALBERT T.		IS, JR.				DIE	יידעה	7 7 7	7F F	A CIT	ON	ME	21.601
-						70 1	בעע	144 T T 1	AV	c., E	AST	UN,	MID	₹1001
	0 1111,	7 1995	Jalia da	whor Ra	dall									



PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician,	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit mermit. Pages 1.2.3 should	nation, or removal.	ked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate by	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physicia	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other trai

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

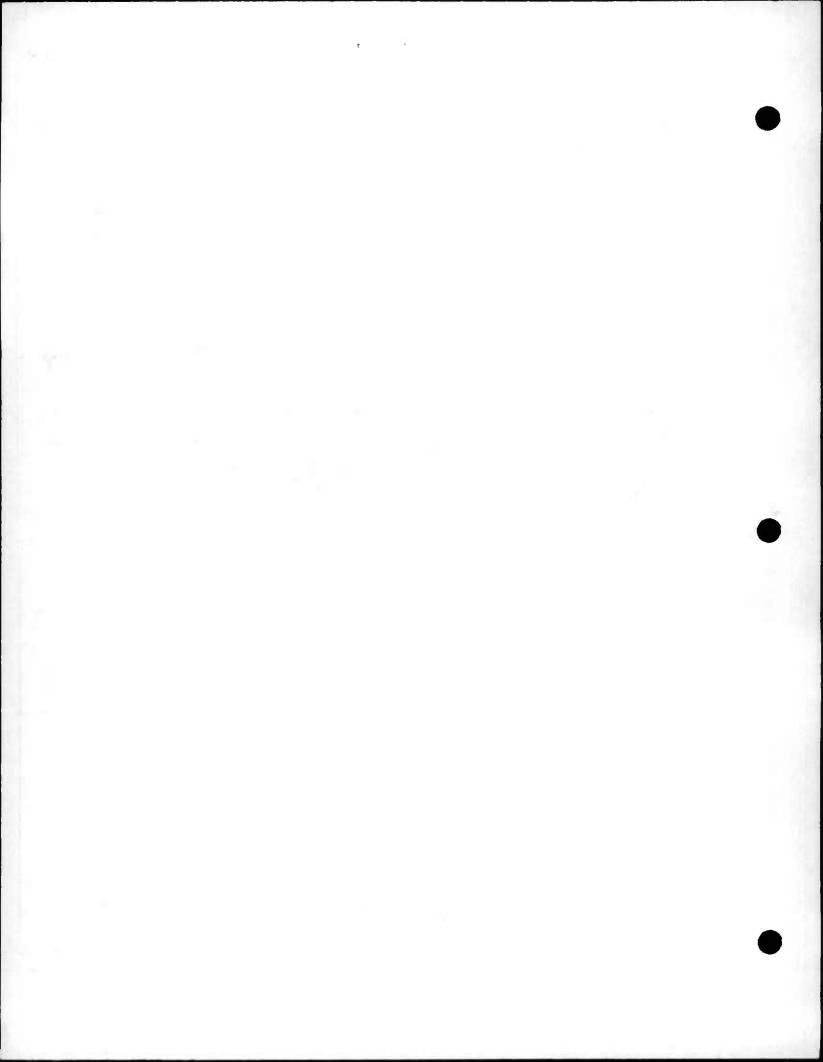
PETER WHITESELL

31. DATE FILED (MONIN, Dev. Very)

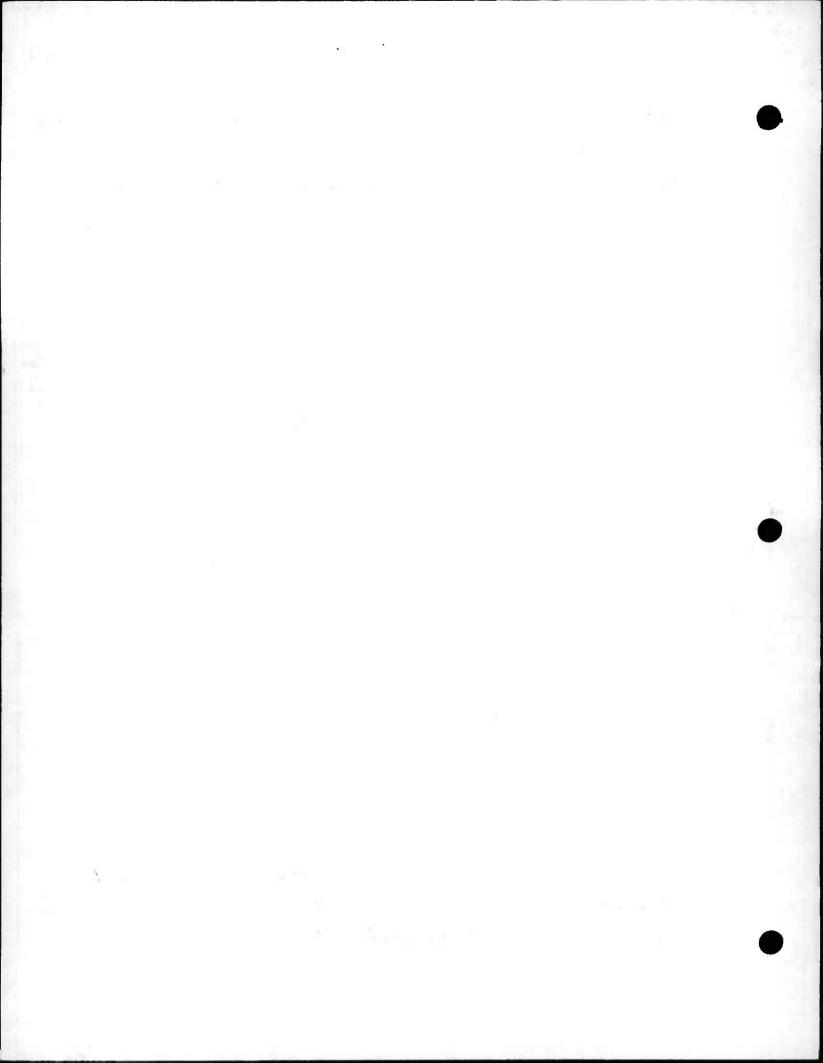
JUL 06 1995

										20	23119		
	1 - FOR STATE REGISTRAR	STATE OF M	ARYLAND /	DEPART	MENT OF A	IEALTH AI	ND MEI	NTAL HYGIEN REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last)						2.	DATE OF DEATH			3. TIME OF DEATH		
	MARGARET A	NN		T11	harty			The state of the s	AY	YEAR	T 00 . M		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. last		IF UNDER 1 YEAR	IF UNDER 24		INITY 4	10	95	5:00 A M PLACE (State or Foreign		
	215-20-2424	1 M 2 TyF	79		MONTHS DAYS		MIN.	(Month, Day, Year)		Country)		
	9e. FACILITY NAME (If not institution, give street	A	19					AR. 23,	_		RYLAND		
œ	MEMORIAL HOSPI				9b. CITY, TOWN (TON	OF DEATN		9c. COU	NTY OF DE	EATN		
DIRECTOR		IAU			Link	OTOM			T	ALBO	\mathbf{T}		
<u>ن</u>	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			40. 0171	TOWN OR LOCAT								
<u>—</u>	MARYLAND TAL	R∩T			ASTON	ION.					10d. INSIDE CITY LIMITS?		
					DION						1 XYES 2 NO		
FUNERAL	10a. STREET AND NUMBER 201 FEDERAL ST	., APT.			101	216	01		10g. CIT	USA	HAT COUNTRY?		
5	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARI	MED	13. WAS DEC	ENDENT OF N	ISPANIC O	RIGIN? (Specify Yes	or No-	14. RACE	- American Indian.		
	1 Never Married 2 Married	FORCES? 1	YES 2 X N	0	If yes, sp	ecify Cuben, N	Mexicen, Pu	erto Rican, etc.)		Bleck,	White, elc.		
ВУ	3 Wildowed 4 Divorced	M M ST D				a Lano	ороспу.			Specify	WHITE		
ED	15. DECEDENT'S EDUCAT	TION	16a. DE0	CEDENT'S U	SUAL OCCUPATION	ON		16b, KIND OF BUS	SINESS/INC	DUSTRY			
ᆸ	(Specify only highest grade co	College (1-4 or 5 +		ve kind of wo Do NOT use	ork done during mo retired.)	st of working							
7	11	College (1-4 or 5+)		OMEN	AKER			OWN	HOM	F			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementarry/Secondary (0-12) 11. FATNER'S NAME (First, Middle, Last) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use relied.) HOMEMAKER O 16. NOT use relied.) 16. NOT use relied.) 16. NOTHER'S NAME (First, Middle, Last)													
HARRY W. PARKS								L. WESI					
19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, St								m, State, Zip Code)					
-	NANCY S. FLUHAR	TY	9	252	HONEYS	SUCKL	E DR	IVE, E	ASTO	N, M	D 21601		
	20e. METHOD OF DISPOSITION	0.000	20b. PLACE A	ND DATE OF	DISPOSITION (Na	me of		DATE 20c. LO	CATION -	City or Tow	rn, State		
	1 Suriel 2 Cremation 3 Remove 4 Donation 8 Other (Specify)	al from State	OLTVF	natory or oth	METERY	7	7-				LS, MD		
	21. SIGNATURE OF FUNERAL SERVICE LICEN					D ADDRESS					20, 10		
	N/FI	March	10 - E	50	NEWN	AM FU	NERA	L HOME	, P.	A.			
	M. K. Lee	Macill		1.	200 9	. HA	RRIS	ON ST.	EA	STON	, MD		
	23. PART i. Enter the diseases, or cor	mplicationa that	ceused the dea	th. Do no	t enter the mo	de of dying,	, auch aa	cerdiec or reapi	ratory an	reat,	Approximete		
- 1	ahock, or heert failure. Liet only one cause on each line. IMMEDIATE CAUSE (Fine)												
-	reaulting in death)	1100591	V 2 50	imo	nary	emb	olrs	m			24 hrs		
	resulting in death) a. Massive pulmonary embolism Due to (or as a consequence of): 24 hrs												
Z	Sequentially list conditions.												
Ĕ	if any, leading to immediate	DUE TO (OR AS A CONSEO	UENCE OF):	:								
CERTIFICATION	CAUSE (Disease or Injury												
	thet initiated events	DUE TO (OR AS A CONSEC	UENCE OF):									
E	resulting in deeth) LAST												
- 1	DADT II Other significant and distance												
₹Ⅱ	PART II. Other aignificent conditions of			aulting in	the underlying	ceuse give	n in Part	i. 24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS AMILABLE PRIOR TO		
ĕ∥	_ iolon aden	ocarcii	roma					1 TYES 2	NO		COMPLETION OF CAUSE OF DEATH?		
핗ㅣ											1 TES 2 AMO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN							TAIN [n					
÷ 1	DID TODACCO USE CONTRI				(Check only one)	OTTOER							
NA.	25. WAS CASE REFERRED TO MEDICAL												
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:		3.00	OTHER:	_	nce 8 Other (Specify)						
1YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DIO	Inpatient 2 -	ER/Outpatient 3 [DOA 4	Nursing Nome		_						
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 27. MANNER OF DEATH	10 SPITAL: Inpetient 2 28e. DATE OF II (Month, De)	ER/Oulpatient 3 [DOA 4	OF 28c. INJI	JRY AT RK?	28d	Other (Specify) DESCRIBE NOW II	JURY OC	CURED			
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 DIO	28e. DATE OF II (Month, Day	ER/Outpatient 3 [NJURY ; Year)	28b, TIME INJUI	OF 28c. INJI NV 1 1 Y	JRY AT RK? 'ES 2 NO	28d		JURY OC	CURED			
┢	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be	28e. DATE OF II (Month, De) 28e. PLACE OF	ER/Oulpatient 3 [28b, TIME INJUI	OF 28c. INJI NV 1 1 Y	JRY AT RK? 'ES 2 NO	28d	DESCRIBE NOW IF			ute Number,		
ED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 27. MANNER OF DEATH 1 Vetural 5 Pending Investigation	28e. DATE OF II (Month, De) 28e. PLACE OF	ER/Ouipatient 3 [NJURY; Veer)	28b, TIME INJUI	OF 28c. INJI NV 1 1 Y	JRY AT RK? 'ES 2 NO	28d	DESCRIBE NOW I			ute Number,		
ED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined	28e. DATE OF II (Month, De) 28e. PLACE OF building, e	ER/Oulpatient 3 [NJURY : 'Year) INJURY — At hom ic. (Specify)	28b. TIME INJUI	OF 28c. INJI NY M 1 7 Bel, fectory, office	JRY AT RK? 'ES 2 INC	28d O 28f.	DESCRIBE NOW IF LOCATION (Street e City or Town, State)	nd Number	or Aural Ao	ute Number,		
ED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29. CERTIFIER (Check only)	28e. PLACE OF building, e	ER/Ouipatient 3 [NJURY Year) INJURY — At horr ic. (Specify) by knowledge, dear	DOA 4 28b. TIME INJUI ne, lerm, str	OF 28c. INJI WO 1 U vo vo vo vo vo vo vo vo vo vo vo vo vo	JRY AT RK? 'ES 2 NC	28d 0 28f.	LOCATION (Street e City or Town, State)	nd Number	or Rural Ro			
ED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 27. MANNER OF DEATH 1 Wetural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	28e. PLACE OF building, e	ER/Ouipatient 3 [NJURY Year) INJURY — At horr ic. (Specify) by knowledge, dear	DOA 4 28b. TIME INJUI ne, lerm, str	OF 28c. INJI WO 1 U vo vo vo vo vo vo vo vo vo vo vo vo vo	JRY AT RK? 'ES 2 NC	28d 0 28f.	LOCATION (Street e City or Town, State)	nd Number	or Rural Ro			
BE COMPLETED BY PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29. CERTIFIER (Check only)	28e. PLACE OF building, e	ER/Ouipatient 3 [NJURY Year) INJURY — At horr ic. (Specify) by knowledge, dear	DOA 4 28b. TIME INJUI ne, lerm, str	OF 28c. INJI WO 1 U vo vo vo vo vo vo vo vo vo vo vo vo vo	JRY AT RK? 'ES 2 NC	28d 0 28f. d due to the time,	DESCRIBE NOW IS LOCATION (Street e City or Town, State) e cause(s) end man date and place, and	nd Number	or Rural Ro			

M.D., 609 B DUTCHMAN'S LANE, EASTON, MD 21601



		1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPA CERTIF	RTMENT OF I	HEALTH AND MI	ENTAL HYGIEN						
		1. DECEDENT'S NAME (First, Middle, Last)					. DATE OF DEATH		3. TIME OF DEATH				
		JOSEPH Wesley					07 15		5 654 A M				
		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. 7	DATE OF BIRTH		BIRTHPLACE (State or Foreign Country)				
Pin		220-26-8870	1 № M 2 🗆 F	64 YRS.		5-5-5	(Month, Pay, Year) (31	MARY (ANd				
3 should	05	9a. FACILITY NAME (If not institution, give s			10.	OR LOCATION OF DEAT	Н	9c. COUNT	Y OF DEATH				
1, 2, 3	5	PRESIDENCE OF DECEDENT	AMC		DALT	MORE	MD	mo	20=BALLICITY				
Pages	DIRECTOR	10a. STATE 10b. COUNTY	Y	10c. Cf	TY, TOWN OR LOCA	TION			10d. INSIDE CITY				
. E .			lbot	S	t. Micha	els			1 X YES 2 NO				
permit.	ERAL	10e. STREET AND NUMBER			10	f. ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?				
an. transk	N N	239 North St.				21663			S.A.				
15-0020 ending physician. as the burial-transit	FUN	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 X YES	2 NO	13. WAS DEC	CENDENT OF HISPANIC pecify Cuban, Maxican, F	ORIGIN? (Specify Yes	or No- 1	4. RACE — American Indian, Black, White, atc.				
the tr	8	3 Widowed 4 Divorced	U.S. Ar	DATES MIV	1 TYES	S 2 NO Specify:			Specify: Black				
21215-0020 If or attending physic for use as the burial		15. OECEDENT'S EDUC (Specify only highest grade	CATION	16a. DECEDENT'S	USUAL OCCUPATION	ON	16b, KIND OF BUS	SINESS/INDU					
21 21 20 m	E	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT	work done during mo ise retired.)	ost of working							
AND 21 the hospital or detached for u	COMPL	11		Heavy E	quipment	Operator	Constuc	tion					
e de the P	ပ္ပ	17. FATHER'S NAME (First, Middle, Last)					(First, Middle, Maiden	Sumame)					
	띪	James Haskins 19a. INFORMANT'S NAME (Type/Print)				Virginia							
5 5 5	유	Helen E. Fields				and Number or Rural Rou							
Pe sage		20a. METHOD OF DISPOSITION	20	b. PLACE AND DATE		St. Micha			21663				
Age 6 ma director, p		1 Burial 2 Cremation 3 Remo	oval from Stata	metery, cremetory or	other place)	Cemetery	1-45		y or Town, Stata Maryland				
		21. SIGNATURE OF FUNERAL SERVICE LIC		aryrana	22. NAME A	ND ADDRESS OF FACIL	TY						
BALIIN er death. Pag the funeral di val.		1 Housing of	6 form			son E. Lec							
after after Dy the moval		23. PART I. Enter the diseases, or c	complications that cause	od the death. Do	not enter the mo	. Talbot S	t. Michae	els, N	laryland 21663				
24 hours after filled in by th ion, or remove the medical		shock, or neert fellure.	Liet only one ceuse on	eech ilne.	not onto: the mo	de or dynig, such e	a cardiac or respi	ratory erres	Approximate interval Between Onset and Death				
= 3 to =	IMMEDIATE CAUSE (Fine) disease or condition												
ompletely il, cremat, il		resulting in death)		A CONSEQUENCE O	NF):								
	z		Mu	-TIPLE	Ope	-42	KILUR	25	į į				
OX 68 e be execut sician and c nor to buri traumatic	CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING											
n = 50 .	할	Cause. Enter UNDERLYING CAUSE (Disease or injury											
Certificate nding physical Hygiene pri		thet initieted events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST											
	B	d											
å å ₹ Ē	CAL	PART il. Other eignificant conditions	s contributing to death i	but not reculting	In the underlying	g ceuse given in Par	t I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS				
9 = 8 = E							1 TYES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
law requires that as been signed lept, of Health a	MED							23	1 TES 2 NO				
- S - S - S	SICIAN:	DID TOBACCO USE CONTR	RIBUTE TO CAUSE C			UNCERTAIN	·						
는 등을 등	호	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TH (Check only one) OTHER:								
SICIAN: The certificate the State	HYS	1 YES 2 NO 27. MANNER OF DEATH	28a. DATE OF INJURY			e 5 🗆 Rasidence 8 🗆							
The with C		1X Netural 5 Pending	(Month, Day, Year)	28b. TIN	JURY WO	VRK?	d. DESCRIBE HOW IN	IJURY OCCUI	RED				
After death	ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY	Y — At home, farm,			t. LOCATION (Street a	nd Number or	Dural Boute Number				
DR ATTENDING DIRECTOR: After Towns after death Them 28 is ma	TED	4 Homicide 8 Could not be	building, etc. (Spe	ictfy)	,	- -	City or Town, State)	THE MOTTED OF	nural noute Number,				
2 年 2 日	COMPLET	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my know	riedge death occurr	ad at the time, date	and place and due to a	ha annual and						
見見だ言	OM								ause(a) and manner as stated.				
THE HOSPI THE FUNED filed within	702773	296. SIGNATOR AND TITLE OF CHITIFIER				29c. LICENSE NUMBER							
五 五 3 6	201	V) Ont	Yenne	MI					IGNED (Month, Day, Year)				
O D v F							\sim	()					
8672	6	TO HAME AND ADDRESS OF PERSON WHO	COMPUTED CAUSE OF DE	EATH (ITEM 27) (Type	. Print)	-	-		1165190				
667 🖁	01	TRIAN LA	COMPUTED CAUSE OF DE	22 S.	Print) CRES	ENE ST	BA	TIMO	7/15/95 125 /47)				

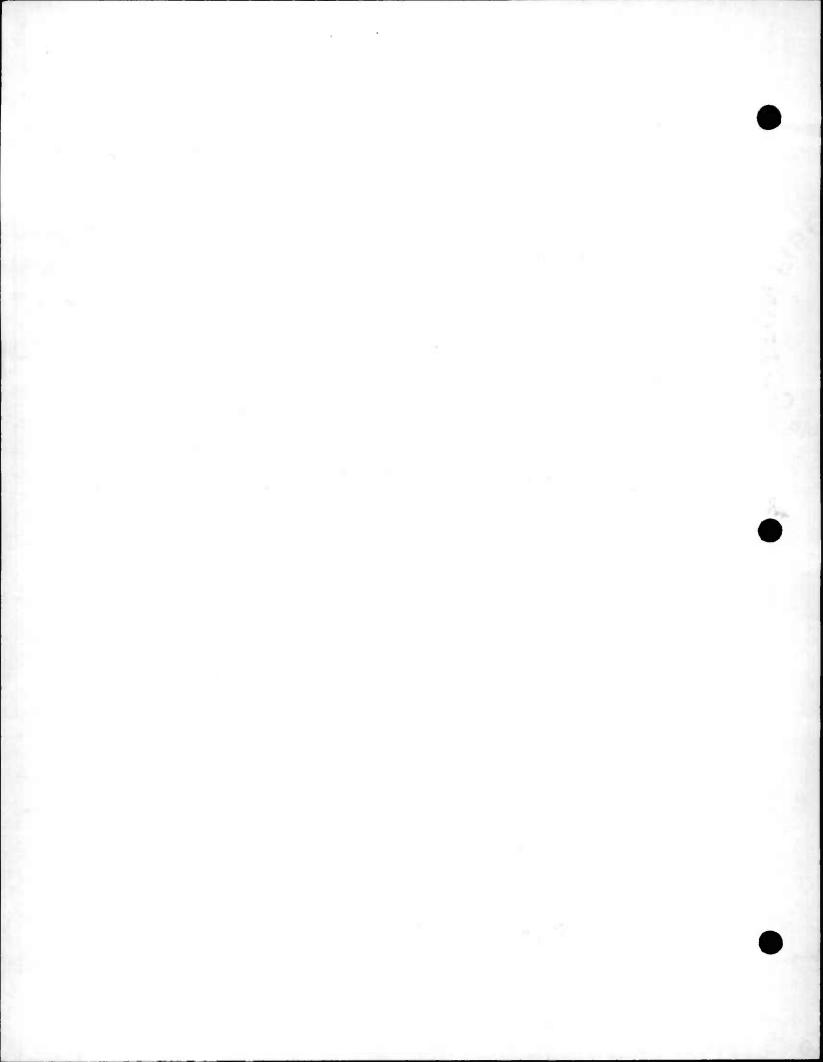


											9	C	5318	1
	FOR STATE REGISTRAR	STATE OF M		DEPAR					MENTA	L HYGIE				
1	1. OECEDENT'S NAME (First, Middle, Last)									E OF DEATN	0.		3. TIME OF OE	ATH
	ROBERT PERRY	FULLER	}						JUN	₹ 30	1 995	YEAR	12:50	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. la	st birthday)	IF UND	ER 1 YEAR	IF UNDE	R 24 HRS.	7. DATE	OF BIRTH		8. BIRTH	IPLACE (State or	
	213-14-3427	1 XM 2 □ F	76	YRS.	MONTHS	DAYS	HOURS	MIN.	OC'	rh, Day, Year)	1918	Countr M 7	RYLAN	
	9a. FACILITY NAME (If not institution, give s	street and number)			9b. CI1	TY, TOWN	OR LOCAT	ION OF D				NTY OF D		
E	408 THE STRAN	D			200	OXF					W. 1157	TALI		
DIRECTOR	RESIDENCE OF DECEDENT	-				0111						17111	301	
1 2	10a. STATE 10b. COUNT			10c. CIT		OR LOCA							10d. INSIDE CI	TY
	MARYLAND TAL	BOT			OX	FOR	D						1 XYES 2	NO
FUNERAL	10e. STREET AND NUMBER					10	H. ZIP COD				10g. CIT	ZEN OF V	VNAT COUNTRY	?
Ä	408 THE STRAN							165				USA		
BY FU	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WA	TYES 2	RMED NO	13	If yes, sp	CENDENT (Decify Cubic 2 1/0	ın, Mexica	an, Puerlo	N? (Specify Yorking Ricen, atc.)	es or No-	14. RACE Black Speci		
_	15 DECEDENT'S FOU	W W II	_										WHI	TE
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Be. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)										USINESS/INC	USTRY		
1	Elementary/Secondary (0-12)	College (1-4 or 5+)		ECUT					Ι,	o Tempa T	SATEC			
M	17. FATHER'S NAME (First, Middle, Lest)	5+	EA.	ECUT	TAE		T			RETAI		TU S	ALES	
		TTED								Middle, Maide		TOOL		
BE	PERRY WADE FULLER ANITA BELMONT SHERWOOD 198. INFORMANT'S NAME (Type/Print) 199. MAILING ADDRESS (Stream and Number of Burnel Stream													
2	196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) WADE R. FULLER 28150 WOODLAND COURT, EASTON, MD 21601													
	20a METNOD OF DISPOSITION							COU		7				
	Buriel 2 Cremetion 3 Rem	oval from State	20b. PLACE cemetery, cre DOVE	ematory or o	ther place	DTC	eme of P	MRT	FDV	7_3	OCATION —		wn, Stata	
	21. SIGNATURE OF FUNERAL SERVICE LIC		_	K FILL	22	. NAME A	ND ADDRE	SS OF FA	CILITY			-	, FID	
	M.E. New	nacy 1	2 C-t	S.F	N	EWN	AM F	UNE	RAL	HOME ST.			I MD	
\vdash	23. PART i. Enter the diseases, or o	complications that	caused the de	eth Do r	ot ente	r the mo	de of du	AKK	TOOL	N 51.	, EA	2101		
	23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arreet, shock, or heart feilure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Finel													
	IMMEDIATE CAUSE (Finel disease or condition										Onset a	nd Death		
1 /	disease or condition resulting in death) a. Trucheseit www. Tibrosis										You	RS		
_	DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF):													
¥	if any, leading to immediate cause. Enter UNDERLYING				,									
트	CAUSE (Disease or injury that initiated events	cDUE TO (C	OR AS A CONSE	OUENCE OF									<u> </u>	
본	resulting in death) LAST	d											1	
2													+	
N N	PART ii. Other eignificant condition	a contributing to d	leath but not i	raauiting i	in the u	nderiyin	g cause (given in	Part I.	24a. WAS AI	N AUTOPSY	24b.	WERE AUTOPSY AVAILABLE PRIOR	
MEDICAL										1 TYES	-		COMPLETION OF OF DEATH?	
ME													1 YES 2	NO
	DID TOBACCO USE CONTI	RIBUTE TO CAU	ISE OF DEA	TH YE	S 🗆	NO E	UNC	ERTAIL	N 🗆					
ĕ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSBITAL	26. PLAC	CE OF OEAT										
\Si	1 🗆 YES 2 🗇 NO	HOSPITAL:	ER/Oulpatient 3	DOA	OTHE		10 5 ⊞ A	sidence	6 🗆 Othe	er (Specify)				
PHYSICIAN:	27. MANNER OF DEATH	26a, DATE OF IN (Month, Day,		28b. TIM	E OF URY	28c, INJ	URY AT		28d. DE	SCRIBE NOW	INJURY OCC	URED		
Β¥	1 Natural 5 Pending 2 Accident Investigation	(, ,,,,,]	M	_	YES 2	ON						
	3 Suicide 6 Could not be	28e. PLACE OF building, et	INJURY - At ho	ome, ferm, s	rtreet, fac	tory, office	•		281. LOC	ATION (Street or Town, State	and Number	or Rural A	oute Number,	
ETE	4 Nomicide determined		,,,						Ony	or lown, State	,			
	29a. CERTIFIER (Check only	CIAN: To the best of m	y knowledge, da	ath_eacum	d at the	lime, data	and place	and due	to the co	use(a) and me	DDer en et-t-	wl.		
COMP	one) 2 MEOICAL EXAMINE												and manner en	hatete
	296. SIGNATURE AND TITLE OF PERTIFIER		h				_			p				
8	2066	1. fre	eller		~	.	1) 7	ENSE NUM	BER		29d. DATE	SIGNEO	(Month, Day, Year	
0	11/-3/6)													

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATN (ITEM 27) (Type, Print)

Friedman, M.D., Scott 403 Marvel Court, Easton, Md 21601 D.

A REGISTRAN'S SIGNATURE



DIVISION OF VITAL RECORDS, P.O. BOX 68760 OR AFTENDING PHYSICIAN: The law requires that the death certificate be

(Check only one)

2

29b. SIGNATURE AND TITLE OF CERTIFIER

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle Leet) 2. DATE OF DEATH 3. TIME OF DEATH Raymond Parker Free, Sr. YEAR 10:05 July 995 м 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 24 HRS. 7. DATE OF BIRTN (Month, Day, Year) 8. BIRTNPLACE (State or Foreign DAVE HOURS 218-30-9331 1 X M 2 | F 90 Aug. 22, 1904 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATN DIRECTOR Citizens Nursing Home Frederick Frederick 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Frederick Frederick XX YES 2 NO hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-transit permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 44 East South Street 21701 United States 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X NO IF YES, GIVE WAR OR OATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Maxican, Puarto Rican, atc.)
 U YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married
3 Widowed 4 Diversed В Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Sales Bakery 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bradley Turner Free BE Martha Ella Richardson notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Raymond P. Free, Jr. 5920 Quinn Orchard Road Frederick, MD 21701 99 20s, METHOD OF DISPOSITION
1 A Burlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Mt. Olivet Cemetery 4 Donation 5 Other (Specify) 7/14/95 Frederick, Maryland medicai examiner 21. SIGNATURE OF FONERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A 1621 Opossumtown Pike Frederick, MD 21702 acro-ci 0 23 PART Enter the diseases, or complications that coursed the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. filled in by t Approximate 0 Interval Between IMMEDIATE CAUSE (Final Onset and Death cremation. other traumatic event, the disease or condition -ancom UNHNOWS completely 6 mm resulting in death) burial. CERTIFICATION and Sequentielly list conditions, signed by the attending physician ar Health and Mental Hygiene prior to DUE TO (OR AS A CONSEQUENCE OF) If any, laeding to immediate cause, Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST injury, or PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 23 shows any 1 YES 2 NO 1 TYES 2 NO t. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: Dept. certificate has the State Dept 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Hem HOSPITAL: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA raing Nome 5 Residence 8 Other (Specily) the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? this c marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural В 1 YES 2 NO After 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, streat, factory, offica building, atc. (Specify) 28 is r 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town. State) DIRECTOR: A COMPLETED 4 Nomicide TO THE HOSPITAL OR ATTO THE FUNERAL DIRECTED BE filed within 72 hours at IMPORTANT: If Item 2 29a. CERTIFIER

> Pearre, M.D. Austin A. 300 West 9th Street Frederick, MD 21701 32. REGISTRAR'S SIGNATURE ROYALL

2-601

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATN (ITEM 27) (Type, Print)

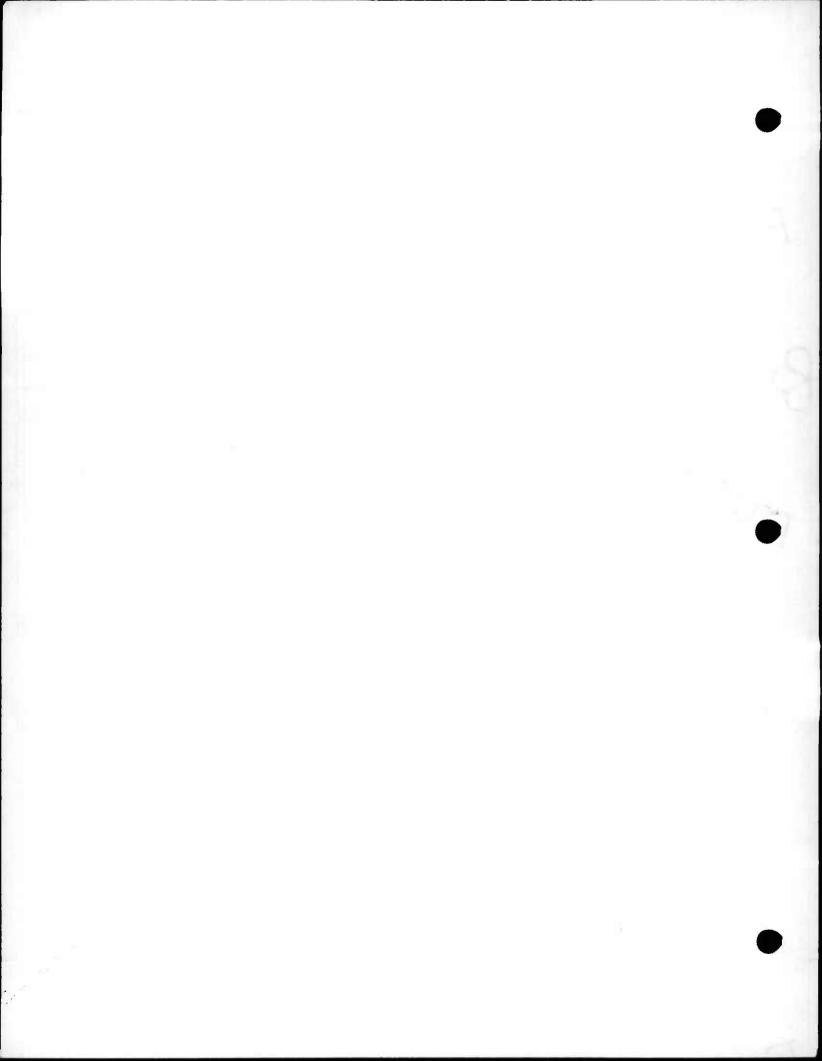
1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER

D 09689

29d. DATE SIGNED (Month, Day, Year)



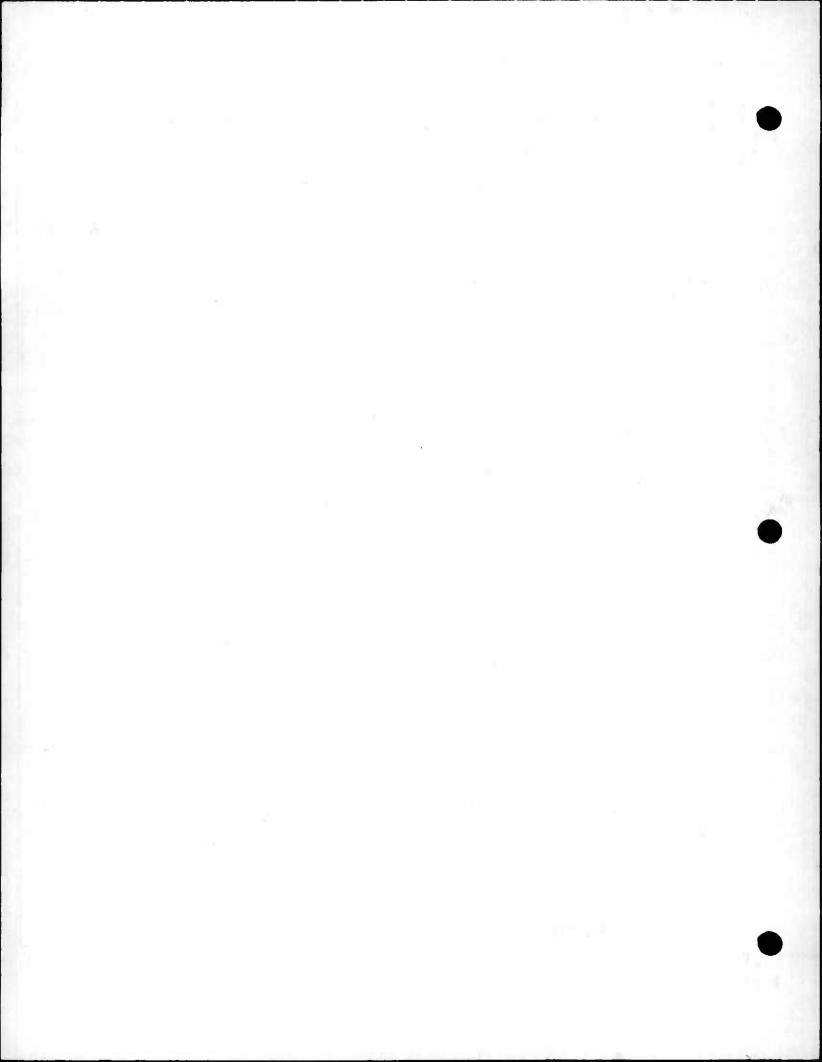
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

٠	FOR STATE REGISTRA
ì	1. DECEDENT'S N
1	John
1	4. SOCIAL SECUR

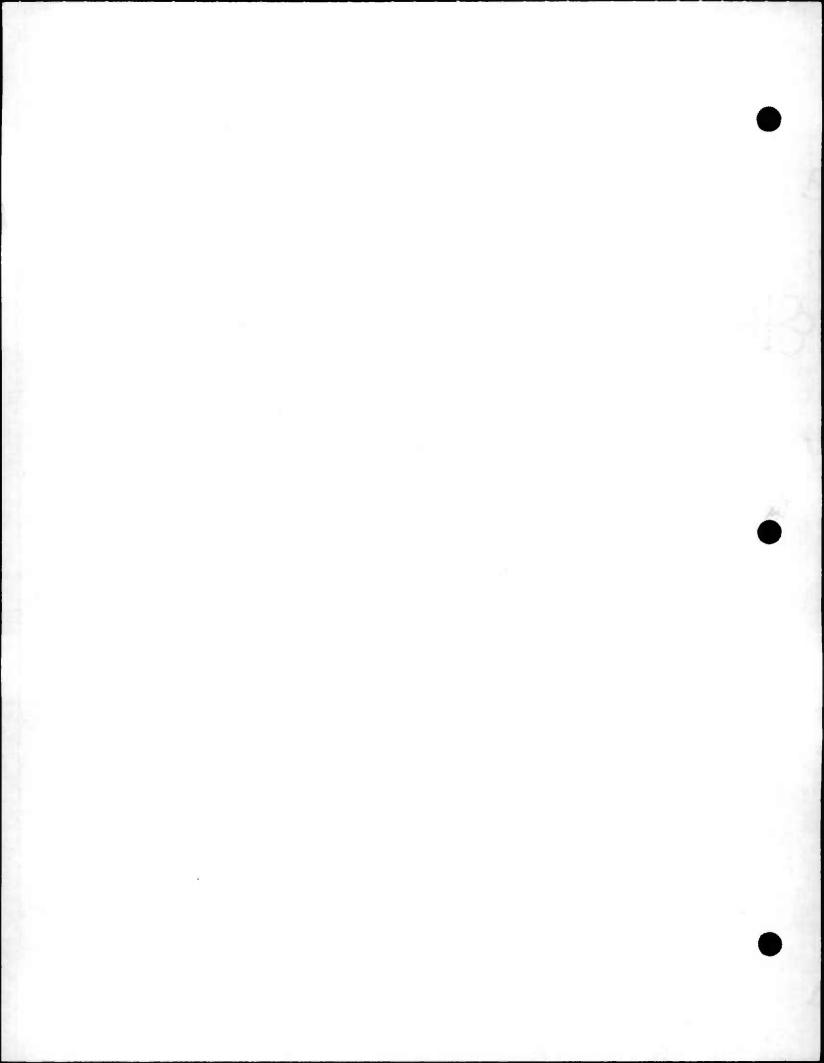
_	REGISTRAR				ERTIF	ICALE	: UF	DEA	Н		REG. NO.			
	1. decedent's name (First, John Gra									2. DATE OF MONTH	De	AY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBI			2 222							9,	T995		3:40 PM
			5. SEX	6. AGE (In yrs. la		IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE OF (Month, D	BIRTH ey, Year)		8. BIRTH Countr	PLACE (State or Foreign
	220-44-243		1/ M M 2 □ F	_77_	YRS.					May		918		NJ
	9e. FACILITY NAME (If not ins	titution, give et	reet end number)			9b. CITY,	TOWN C	R LOCATIO	ON OF DE		11311		NTY OF D	
DIRECTOR	Frederick	Memor	ial Hos	spital		Fr	ede	ric	k			Free	deri	.ck
Ä	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN C	R LOCAT	ION						10d. INSIDE CITY
	MD	Frede	rick		Fr	eder	ick	:						LIMITS?
A	10e. STREET AND NUMBER				101	. ZIP CODE				10g. CIT	IZEN OF W	THAT COUNTRY?		
FUNERAL	5823 Box E	lder	Court					2170	01				S.A.	
ا څ	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AI	RMED	13. 1	WAS DEC	ENDENT O	F HISPAN	C ORIGIN?	Specify Yes	or No-	14. RACE	- American Indian,
	1 Never Merried 2 I		IF YES, GIVE W	AR OR DATES	NO			2 NO		, Puerto Rice	in, etc.)		Specia	, White, etc.
BY	1946-1948											"white		
	15. DECE (Specify only	DENT'S EDUC	ATION completed)	16e, Di	CEDENT'S	USUAL OC	CUPATIO	ON of words	_	16b. KI	ND OF BUS	SINESS/INC	DUSTRY	
<u> </u>	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.)													
린		Me	d. scho	ool 1	Phys:	icia	n			P	riva	te r	orac	tice
COMPLETED	17. FATHER'S NAME (First, Mic	idle, Last)						18. MOTH	ER'S NAM	AE (First, Midd				
	Martin C.	Fawc	ett					Duit	-b v	anVl	iot	,		
BE	190. INFORMANT'S NAME (Ty		000	19	b. MAILING	ADDRESS	(Street e			oute Number,		n State 7ir	Codel	
2	Ruth F. H	211												
1	20e. METHOD OF DISPOSITION		·	20b. PLACE					Gai					20878
	1 - Buriel 2 - Cremetion	3 🗆 Remo	val from State	cemetery, cri	ematory or o	her place)		me or		DATE				
	4 Donation 5 Other (nith			111.00.00			Smi	ths	ourg	. Md.			
	11. SIGNAL OF FORENAL	A T	i K I A	_				D ADDRES		eral	TT			
	111.001	- 6	Weth							e. M				
	23. PART i. Enter the dis	eeses, Dr C	omplications that	t caused the de	eeth. Do r	ot enter	the mo	de of dvi	ng auch	es cerdier	Dr. reeni	U8.32	3	Approximate
1	anock, or ne	art fallure. L	ist Dniy one ceu	se on each line	9.	2 (2) O 5 N					в. теорі	raibiy ari	eut,	Interval Between
- 1	iMMEDIATE CAUSE (Fine disease or condition	oi	1011	TE MV	Elm	0.11-	110	150	We	4.0				Onset and Deeth
	disease or condition resulting in deeth) ACUTE MYELOSENOUS LEUKEMIA 4 DAYS DUE TO (OR AS A CONSEQUENCE OF): APLASTIC ANEMIA 4 MONTHS													
	APLASTIC ANEMIA 4 MONTHS													
CERTIFICATION	Sequentielly list conditions,													
F	If any, leeding to immediate cause. Enter UNDERLYING													
	CAUSE (Disease or Injury 6.													
ĒI	that initiated events resulting in deeth) LAST		502 10	(OII AS A CORSE	OUENCE OF):								
英		d.	•											
	PART ii. Other algnificen	t conditions	contributing to	deeth but not	reaulting i	n the un	derlying	ceuse q	iven in F	Part i. 24	a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
EDICAL	PORCINE 1	40RTT	c VAL	VE							PERFOR	MED?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE
	STAPHYLL	CACCO	IS PPI	AFRAIL	000	SEL	217			- 1	YES 2	NO		DF DEATH?
Σ														1 TES 27 NO
PHYSICIAN:	DID TOBACCO US		IBUIE IO CA					- UNC	ERTAIN					
o l	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:	26. PLA	E OF DEAT	OTHER	, , ,							
YS	1 TYES 2 NO		Inpatient 2		□ DOA			5 □ Ra	eldence 6	Other (S	pecify)			
표	27. MANNER OF DEATH 1 Natural 5 P		26e. DATE OF (Month, Da		26b. TIMI INJ		28c. INJU	JRY AT		26d. DESCRI	BE HOW II	JURY OCC	CURED	
β		ending vestigation				M-	1 🗌 Y		NO					
		ould not be	28e. PLACE Of	F INJURY — At he etc. (Specify)	me, farm, s	treet, facto	ory, office			261. LOCATIO	N (Street e	nd Number	or Rural Re	oute Number,
	4 Homicide de	rtermined		10,700,7					i	City or it	wn, State)			
COMPLETED	29a. CERTIFIER	YING PHYSIC	IAN: To the best of	my knowledge de	ath occur-	d at the st	me date	and elec-	and due 1	o the course	and =c=	and an -1 :		
\$ 1														and manner ee atsted.
			-			.,, 01					biace, en			
BE	29b. SIGNATURE AND TITLE (JF CERTIFIER	8xh	NIX	Ke	17	40	29c. LICE	NSE NUMI	DER 7/1		29d. DATI	SIGNED	(Morth, Day, Year)
2			1	0.10	-070	- C	MD	·	031	101		P /	191	/75
-	BRIAN M.	O'CON/	VOR MA	SE DE DEATH (ITE	M 27) (Type,	Print)	NTH	157	A	RESE	RICK	- 11	0 2	1701
	31. DATE FILED (Month, Day, Ye	er)	32. REGISTRA	PLE SIGNATURE			_					/		
44	1111 1 1	/ TUUL	THUA O	URULLIANA	14/-11	ı								



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

_ [1. DECEDENT'S NAME (First, Middle, Last)				IOAII		DEA		neg. No			
		Minnie	Farrel:	1					1	July 21	199	95 3.1	
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le:	sst birthday)	IF UNDER	T .	IF UNDER	24 HRS	7. DATE OF BIRTH		8. BIRTHPLA	CE (State or Foreign
2		020 18 7226	1 - M 2 F	91	YRS.	MONTHS	DAYS	HOURS	MIN.	1271271	903 F	Rhode	Island
shoul	_	9e. FACILITY NAME (If not institution, give et				9b. CITY	r, TOWN C	OR LOCATIO	ON OF DEA	тн			
2, 3	DIRECTOR	717 Oak Hill A	ve.			Hag	ers	town			Wash	ningt	on
Jes 1,	EC	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	Y		10c. CIT	Y, TOWN C	OR LOCAT	TION				100	INSIDE CITY
<u> </u>	F	Maryland Was	hington			ers							LIMITS?
permi		10e. STREET AND NUMBER			1			f. ZIP COOE			10g. CITIZ		
in. ransit	FUNERAL	717 Oak Hill A	.ve.					21740	0			USA	
20 hysicia urial-t	J.	11. MARITAL STATUS 1 Never Married 2 Merried		YES 2 X	RMED	13.	WAS DEC	ENDENT OF	F HISPANIC	C ORIGIN? (Specify Yes Puerto Rican, etc.)	or No-	14. RACE — / Black, Wi	American Indian, nite. etc.
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should notified at once.	B√	3 X Widowed 4 Divorced	IF YES, GIVE W					2 X NO	Specify:				
215 attend	9	15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. Di	ECEDENT'S	USUAL O	CCUPATIO	ON .		16b. KIND OF BUS	SINESS/IND		
21 tal or lifer u	COMPLETED	Elementery/Secondary (0-12)	College (1-4 or 5+)	+) Iffe	le. Do NOT us	se retired.)			_	01	_		
AND the hospi detached	MP	8			shoe	St	1010					actur	ing
YLA by the be det		17. FATHER'S NAME (First, Middle, Last) Aaron	Mi	chalov	rich			Dor		E (First, Middle, Maiden	Sumame)	a. SHITHPLACE (State or Foreign Rhode Island UNITY OF DEATH Shington 10d. INSIDE CITY LIMITS? 1 1 2 YES 2 NO TIZEN OF WHAT COUNTRY? USA 14. RACE — American Indian, Black, White, etc. Specify: White HOUSTRY Facturing Holtzman Typ Code) Add. 21740 City or Town, State 1, Mass. N. Potomac St. Stown, Md. Treat, Approximate interval Between Onset and Death Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Approximate interval Between Onset and Death Add Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Approximate interval Between Onset and Death Ap	
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	2	Lilliam Moore		7	17 0	ak 1	Hil:	1 Av		lagersto	wn, N	Md. 2	
BALTIMORE, er death. Page 6 may be the funeral director, page val.		20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)		206. PLACE	AND DATE OF	Tellspos	ete1	me of ry	7/2	0ATE 20c. LO 24/95Met1	cation – c	ty or Town, s , Mas	State S •
h. Pag eral di		21. SONATURE OF FUNERAL SERVICE LICI	ENSEE	0		22.	NAME AN	ND AODRES	S OF FACIL	ury	OS M	Dot	C+
0 = 0		Lerald of O	Munc	K				ral 1					
A # 56 8		23. PART I. Enter the diseases, or or ahock, pr heart failure. L	complications that	caused the de	eath. Do n	not enter	tha mo	de of dyir	ng, auch	aa cardiac or respi	ratory arre	eat,	Approximata
filled in the med	}	IMMEDIATE CAUSE (Finel	σ										
within 24 the		disease or condition resulting in death)	. Me	umo	nic	1							days
	_	_	OUE TO	OR AS A CONSE	OUENCE OF	f): 							W No
OX 68 e be execute sician and c rior to buria traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSE	OUENCE OF	P):							Mouly
BOX ate be e hysician prior to	₹	cause. Enter UNDERLYING CAUSE (Disease or injury	. Dy	spha	aio	2							Month
i, P.O. BOX leath certificate be attending physician mtal Hygiene prior it y, or other trau	TH	that initiated events resulting in death) LAST	DUE TÓ	OR AS A CONSE	OUTNICE OF	Th:							
P. P.	H	resulting in death, LAST	d										
D the d we		PART ii. Other aignificant conditions	s contributing to	death but not r	resulting i	in the un	nderlying	cause g	iven in Pr				
ECORD quires that the signed by th Health and Mows any injection	MEDICAL									PERFOR		COM	APLETION OF CAUSE
	WC 11												
AL RE he law req has been e Oept. of	Z	DID TOBACCO USE CONTR	RIBUTE TO CAL					UNCE	ERTAIN				
F # # # F	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		CE OF OEAT	OTHER	R:						
PHYSICIAN: The this certificate with the State	HYS	1 VES 2 DAG	1 Inpetient 2 I		3 DOA	4 🗆 Nurs				Other (Specify)			
- c = > +1		1 Pending	(Month, Day		INJU	URY	WOI	PK?		28d. OEŞCRIBE HOW II	NJURY OCC	JRED	
ATTENDING ATTENDING ECTOR: After s after death	D BY	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF	F INJURY — At ho	ome, farm, s	street, fact				et. LOCATION (Street a	and Number o	or Rural Route	Number,
DIVISION L OR ATTENDING I OURECTOR: After hours after death item 28 is man	ETE	4 Homicide determined	25.151.7	nte. (Specify	1.27					City or Town, State)			
DIV AL OR A IL OIRE	COMPLET									the cause(s) end men			
HOSPITAL FUNERAL WITHIN 72	Š	one) 2 MEDICAL EXAMINER	R: On the basis of exa	amination end/or	Investigation	n, in my o	pinion, de	eath occure	d at the tim	ne, date end piece, en	d due to the	ceuse(s) end	menner ee stated.
	BEC	296. SIGNATURE AND JUTLE OF CENTIFIER						29c. LICEN	NSE NUMBE	ER	29d. DATE	SIGNED (Mon	ith, Day, Ybar)
55 54 54 54 54 54 54 54 54 54 54 54 54 5		Cara Com	ence	1			D1433 \1-22-95					95	
		30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	E OF DEATH (ITE				/.	1.10	14	7	. 1	. 000
	-	31. DATE FILED (Month, Day, Year)	32. REGISTRAR	R'S SIGNATURE	1160	8K	en	140	TUE	Mager	1100	14/4	2/1180
		JUL 2 5 1995 M	ili d'audio	or Rendall						•			



Pages 1, 2, 3 should hours after death. Page 6 may be retained by the hospital or attending physician. At in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pe ysician and completely filled in by the prior to burial, cremation, or removal. traumatic event, the attending physician Mental Hygiene prior to other n signed by the Health and N been s OR ATTENDING PHYSICIAN: The law has be Dept. r this certificate h 6 is marked, DIRECTOR: After the hours after death was 28 TO THE HOSPITAL OR AT
TO THE FUNERAL DIRECT
be filed within 72 hours a
IMPORTANT: If Item 2

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Thomas Y. Ko

JUL 20 1995

31. DATE FILED (Month, Day, Year)

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Green 5:16 AM JULY 4. SOCIAL SECURITY NUMBER B. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH (Month, Day, Year) Feb. 29, IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DAYS HOURS 578-14-2540 1 M 2 TE 79 1916 Washington, DC 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington Adventist Hospital Takoma Park Montgomery 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Suitland 1 X YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 3407 Navy Day Drive 20746 United States 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 1 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yea, specify Cuban, Mexican, Puarlo Rican, atc.) BΥ 1 YES 2 NO Specify: 3 Widowed 4 Divorced Black COMPLETED 15. DECEOENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12 Domestic Self Employed 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Phillip Sherman Green Mary Cupid BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Paul E. Green 3407 Navy Day Drive, Suitland, Maryland 20a. METHOO OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State 1 Burial 2 Crematton 4 Prometion 5 Stother (Specify) Entonomen Cedar Hill Cemetery 7/21/95 Suitland, Maryland 22. NAME AND ADDRESS OF FACILITY
JORDAN FUNERAL SERVICE 4001 Benning Road, N.E., Washington, D. C. 23. PART i. Entar the diseasas, er complications that caused tha death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart fallure. Lim IMMEDIATE CAUSE (Final Onset and Death disease or condition ventricular resulting in desth) DUE TO (OR AS A CONSEQUENCE OF) atherosclerote CERTIFICATION Sequantially list conditions, if any, laading to immediate Congrettue ;
DUE TO (OF) AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? vascular distre 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetiant 2 | MER/Outpetient 3 | DOA OTHER: 1 - YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF CEATH 26a. OATE OF INJURY 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28c. INJURY AT WORK? 1 X Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 26e, PLACE OF INJURY — At home, term, atreet, factory, office building, etc. (Specify) 3 Suicide 28t. LOCATION (Street and Number or Rural Routa Number, City or Town, State) 8 Could not be detarmined COMPLETED 4 Homicide 29a. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner ea stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Ony, Year) BE

PLESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

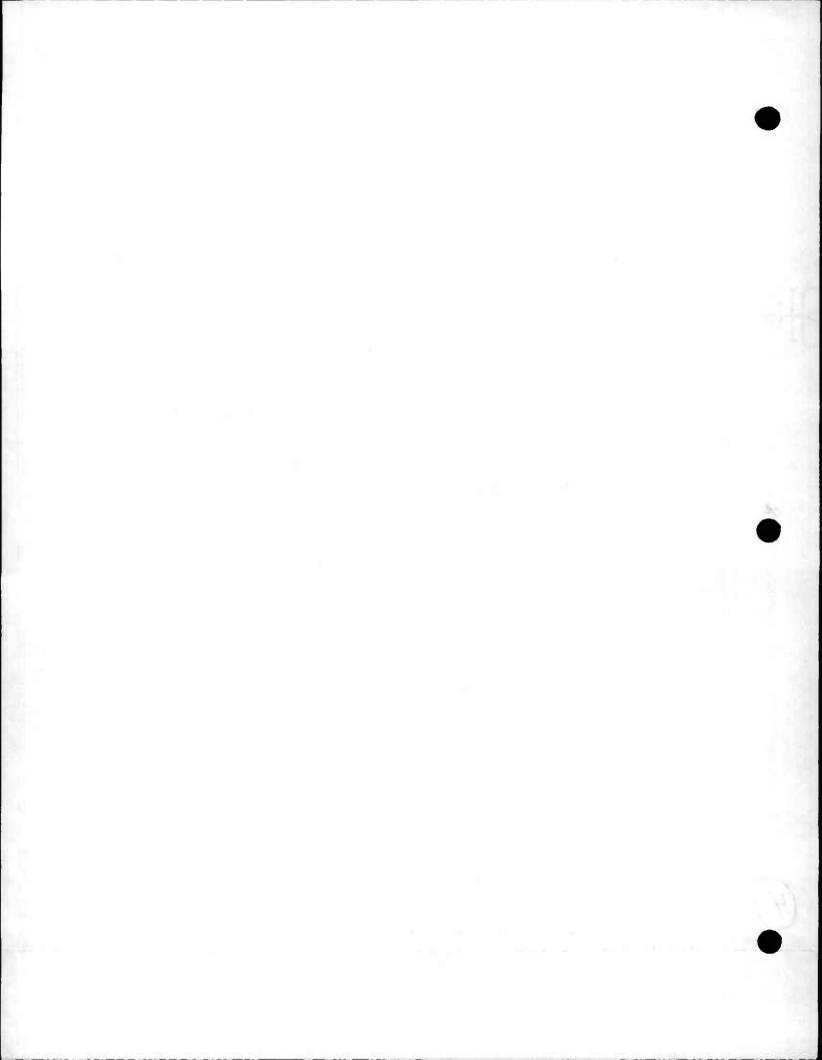
32. REGISTRAR'S SIGNATURE

DHMH-16 Ray 1/89

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8100 Good Luck Road, Suite 302, Lanham, Maryland



لير	BALTIMORE, MARYLAND 212	rs after death. Page 6 may be retained by the hospital or a	
d	R	4 hours	1000
	DIVISION OF VITAL RECORDS, P.O. BOX 68760	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or a	DIOCTION After the book have been been already by the standard and an address that the standard to the standar

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY FUNERAL DIRECTOR 215-0020 TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF H		HYGIENE
CERTIFICATE OF	DEATH	REG. NO.

1 - FOR STATE REGISTRAR	STATE OF MARY	AND / DEPARTMEN CERTIFICAT	NT OF HEALTH AND TE OF DEATH	MENTAL HYGIENE REG. NO.						
1. DECEMENT'S NAME (FIRST, A) 4. SOCIAL SECURITY NUMBE	d Green	SR.	NER 1 YEAR IF UNDER 24 HRS.	2. DATE OF GEATH MONTH 7. DATE OF BIRTH	- 95	3. TIME OF OEATH 6 00 Am M HPLACE (State or Foreign				
577-26-72	1 M 2 F 7	2 YRS. MONTH		12 10/2	Coun	by Pa				
MANOR CARE I	NURSING HOME		Largo			Georges				
MD.	Prince Georges	10c. CITY, TOWN	or location lensburg			10d. INSIDE CITY LIMITS? 1 X YES 2 □ NO				
	merson Street, #4	23	10f. ZIP CODE 20710		10g. CITIZEN OF	WHAT COUNTRY?				
11. MARITAL STATUS 1 Never Married 2 M 3 Widowed 4XX Divorce		2 XNO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Mexicen, Puerto Rican, etc.) 1 YES XXNO Specify: Black							
(Specify only I	DENT'S EDUCATION highest grade completed) 12) College (1-4 or 5+)	life. Do NOT use retired.	e during most of working .)	ing most of working						
12th 17. FATHER'S NAME (First, Midd	Idle, Last)	Shoemake		N/A	Name and 1					
	iam Charles Bishop	o Green		18. MOTHER'S NAME (First, Middle, Maiden Surneme) Meauvell Handley						
19e. INFORMANT'S NAME (Typ			SS (Street end Number or Rural							
Geraldine Gr		12401- Ap	plecross Dr.	Clinton, M	d. 2073	5				
20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 4 Donation 5 Other (S	Specify) Car	b. PLACE AND DATE OF DISPO metery, crematory or other place ATTRONY METRON	DSITION (Name of		ATION City or To	own, State				
21. SIGNATURE OF FUNERAL			Hackett's F	ACILITY						
Me	lta w. Hack	OST	814- Upshur							
snock, or nee	23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, auch as cardiac or reapiratory arrest, shock, or heart feliure. List only one cause on each line. Approximata interval Batween Onset and Death disease or condition									
Sequentisily list condition if sny, leading to immedicause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A DUE TO (OR AS	A CONSEQUENCE OF):	astas		<i>T</i>	6/95				
PART II. Other significant	t conditions contributing to death b	out not resulting in the u	underlying ceuea given in	Part i. 24e. WAS AN A PERFORM	ED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
DID TOBACCO USI	E CONTRIBUTE TO CAUSE C	F DEATH YES	NO A LINCEDTAIL		1	1 TES 2 NO				
25. WAS CASE REFERRED TO I	MEDICAL	26. PLACE OF DEATH (Check								
1 TES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outs	petient 3 DOA 4 DXNL	R: raing Home 5 - Residence	6 Other (Specify)						
27. MANNER OF DEATH 1 Natural 5 Pe 2 Accident Inv	28e. DATE OF INJURY (Month, Day, Year) vestigation	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW IN.	JURY OCCURED					
	28e. PLACE OF INJURY building, atc. (Special property)	— At home, farm, street, facility)	ctory, office	28t, LOCATION (Street en City or Town, State)	d Number or Rural i	Route Number,				
	FYING PHYSICIAN: To the best of my know AL EXAMINER: On the beele of examination					e) end menner ee stated.				
294- SIGNATURE AND TITLE O	sh andle	1, M1	29c. LICENSE NUI	715	►7/17	(Month, Day, Year)				
RAKES 1-		-	ALLANTI	FOXLN, T	BOWI	12 MD 20715				
JUL 20		ur hardall				- 1				

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL

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31. DATE FILED (Month, Day, Year)

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32. REGISTRAR'S SIGNATURE

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OF ATTENDING PHYSICIAN. The law implicing that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician or properties of the	DIFFICION: After this certainant has been sugned by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buria	nouns after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.	Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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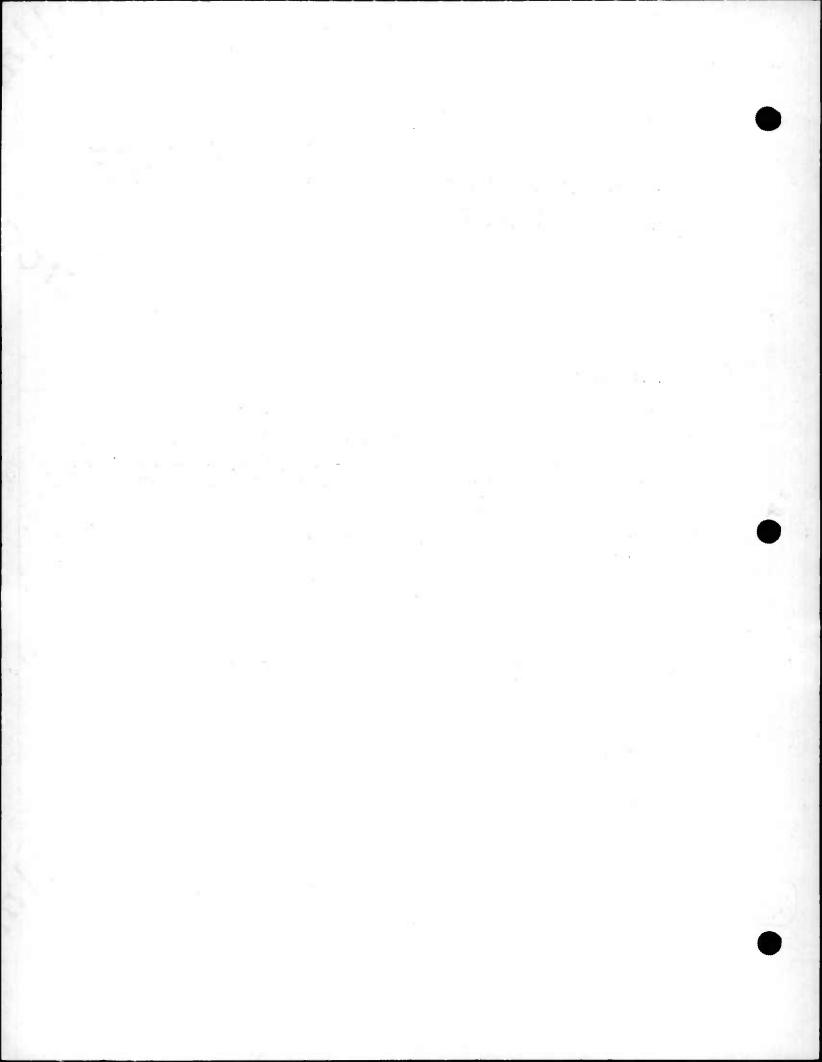
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH largare Green 7:08 A.M wa July 4. SOCIAL SECURITY NUMBER 7. DATE OF PIRTH
(Month, Day, Year)
Jan. 29, 1920 5. SEX 6. AGE (In vrs. last birthda. F UNDER 1 YEAR IN UNDER 24 HRS. 705-12-2937 Georgia 1 🗆 M 2 💥 F 75 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Southern Maryland Hospital Center Clinton Prince George's 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Oxon Hill 1 TES 2 NO FUNERAL 10e, STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20745 U.S.A. 1515 Ferguson Lane 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEOENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 12 Hospital Administrator Hospital 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) William P. Plumley Anne Thompson notified at BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO AOORESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 7711 Wilson Way, Ft. Washington, Md.20744 Mary Chaney METHOD OF DISPOSITION
Burtal 2 Cremation 3 Rem 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must Cedar Hill Cemetery 7/22/95 Donation 5 Other (Specify) Suitland, Maryland examiner SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feliure. Liet only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition DUE TO (OF AS A CONSEQUENCE OF) tant resulting in death) CERTIFICATION Sequantially liet conditiona, OUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate 7/19/95 at cause. Enter UNDERLYING Olavbruch CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF) MA 80. reaulting in deeth) LAST PART II. Other eignificent conditions contributing to death but not resulting in the undarlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? Arton 1 YES 2 NO OF OEATH? 1 _ YES 2 _ NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES $\ \square$ NO $\ \square$ UNCERTAIN $\ \square$ PHYSICIAN: 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL OTHER: 1 TYES 2 NO 1 N Inpatient 2 - ER/Outpatient 3 - DOA 6 - Other (Specify) 27. MANNER OF OEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED 1 Natural BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER 1 📈 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner ee stated. FLINERAL within 72 I 2 MEDICAL EXAMINER: On the basis of TO THE HOSPITA
TO THE FLINERA
De filed within 7
IMPORTANT: on end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE Ju . M.D D 35295 1119198 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Satish Jumani, M.D.

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RE, MARYLAND 21215-0020	nay be retained by the hospital or attending physic	name & should be detected for our or the bull-
ALTIMO	death. Page 6	a funeral directo
DE DE	24 hours after	filled in hy th
DIVISION OF VITAL RECORDS, P.O. BOX 68760 🙈 BALTIMORE, MARYLAND 21215-0020	DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physic	DIRECTOR's After this certificate has been signed by the attendion physician and completely filled to by the trineral director page 5 chould be detached to:
DIVISION O	DR ATTENDING PHYS	DIRECTOR: After this

31. DATE FILED (Month, Day, Year)

14 1995

CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH 1995 10 larence July Green 2:05 Рм Spencer 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Morth, Day, Year)
March 31, DAYS HOURS 216-09-4442 1 X M 2 | F 80 YRS. 1915 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Easton Memorial Hospital Easton Talbot RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Talbot 0xford 1XX YES 2 | NO permit. FUNERAL 10s. STREET AND NUMBER 101. ZIP COOE 10g, CITIZEN OF WHAT COUNTRY? burial-transit 216 Tilghman Street 21654 USA ician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 YO 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rid 1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced **Black** COMPLETED 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEOENT'S EOUCATION (Specify only highest grade complete 16b. KINO OF BUSINESS/INOUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12th Plumber Plumbing 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James Green notified at Sarah Hayward BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Laura Vineta Brown Green 216 Tilghman Street, Oxford, Md. 21654 pe 20s. METHOD OF DISPOSITION

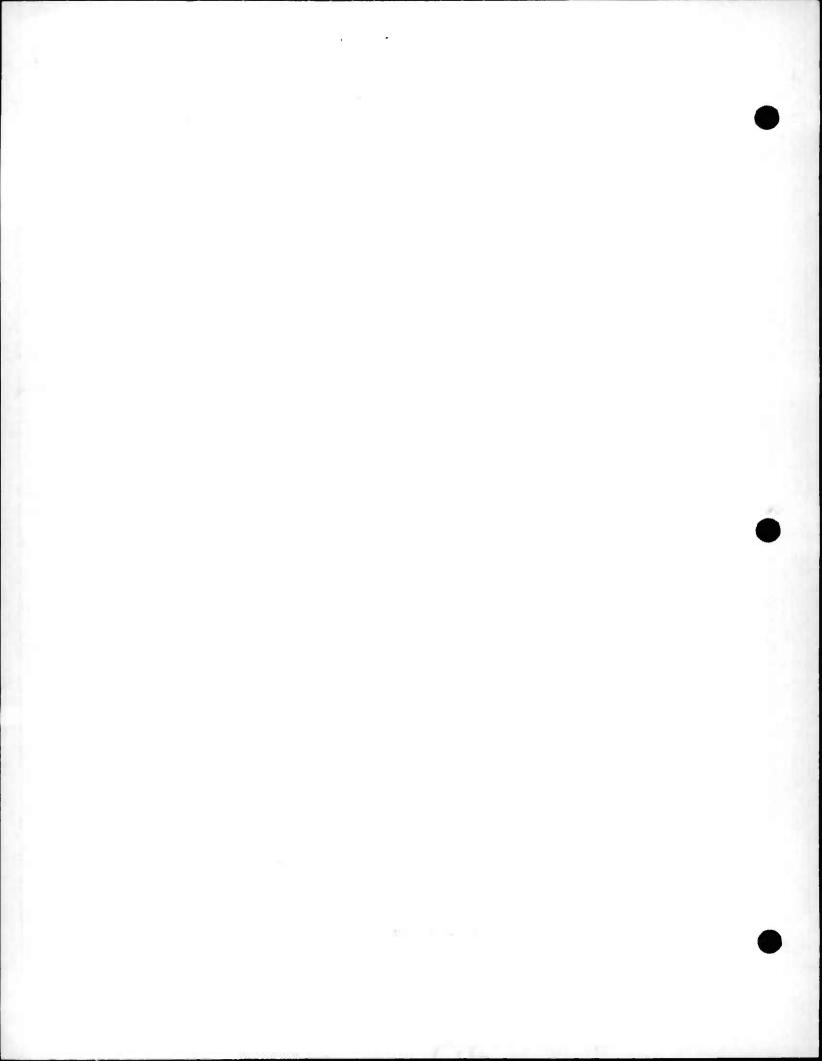
1 X Burial 2 Cremation 3 Removel from State
4 Donation 5 Other (Specify) 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Screamersville Cemetery 7/15/95 Oxford, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADORESS OF FACILITY Bennie Smith Funeral Services P.O. Box 1687, Easton, Md. 21601 cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the daeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. medical Approximata interval Between IMMEDIATE CAUSE (FIRM Onset and Death injury, or other traumatic event, the disesse or condition 0 Dancreas 6 WKS resulting in death) has been signed by the attending physician and cor-Dept. of Health and Mental Hygiene prior to burial, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): PART II. Other algnificent conditions contributing to death but not resulting in the undarlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE shows any 1 TES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🗵 PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) the State D item HOSPITAL: OTHER: 1 YES 2 NO Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED With Natural 1 YES 2 NO BY death 2 Accident TO THE HOSPITAL DR ATTENDING TO THE FUNERAL DIRECTOR: Afte be fied within 72 hours after deal IMPORTANT: If Item 28 is m 3 Suicide 28a. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(a) and menner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)

7-/(-95 BE 29c. UCENSE NUMBER les 38990 a 0 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Charles E. DiNapoli, MD, 404 Marvel Ct, Easton, Md. 21601

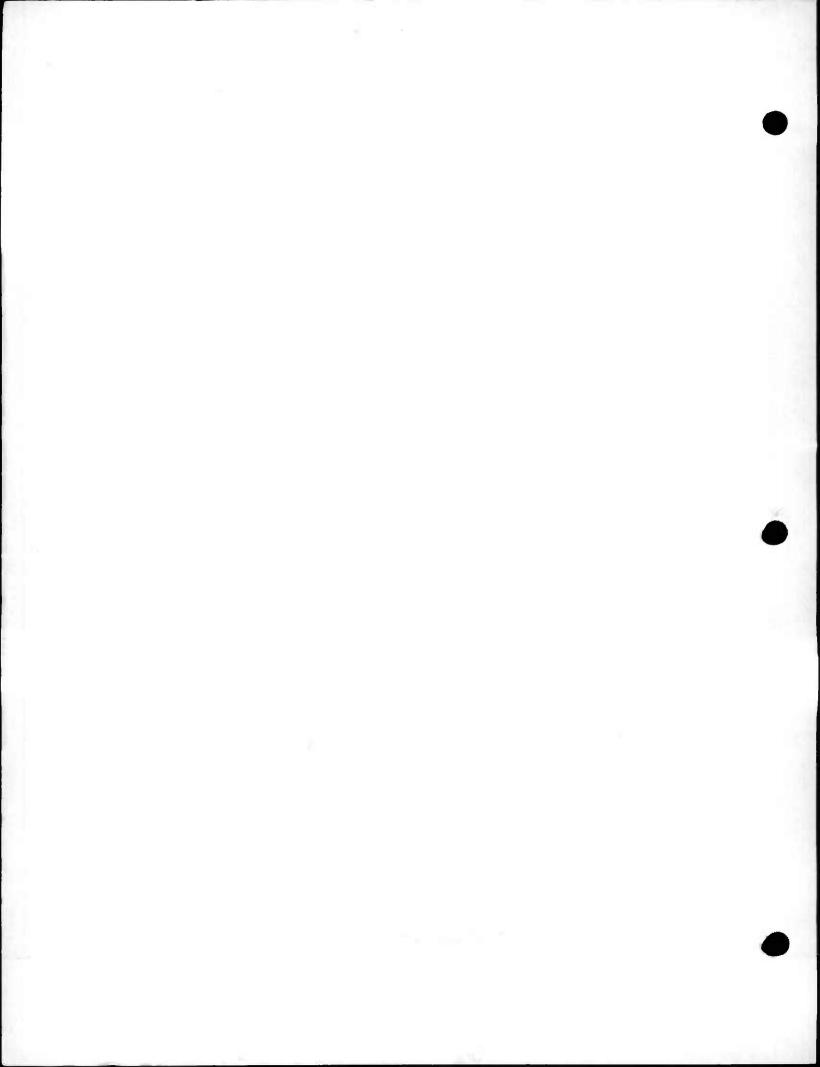
32. BEGISTRAR'S SIGNATURE July otherster Redall



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an found refer to death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

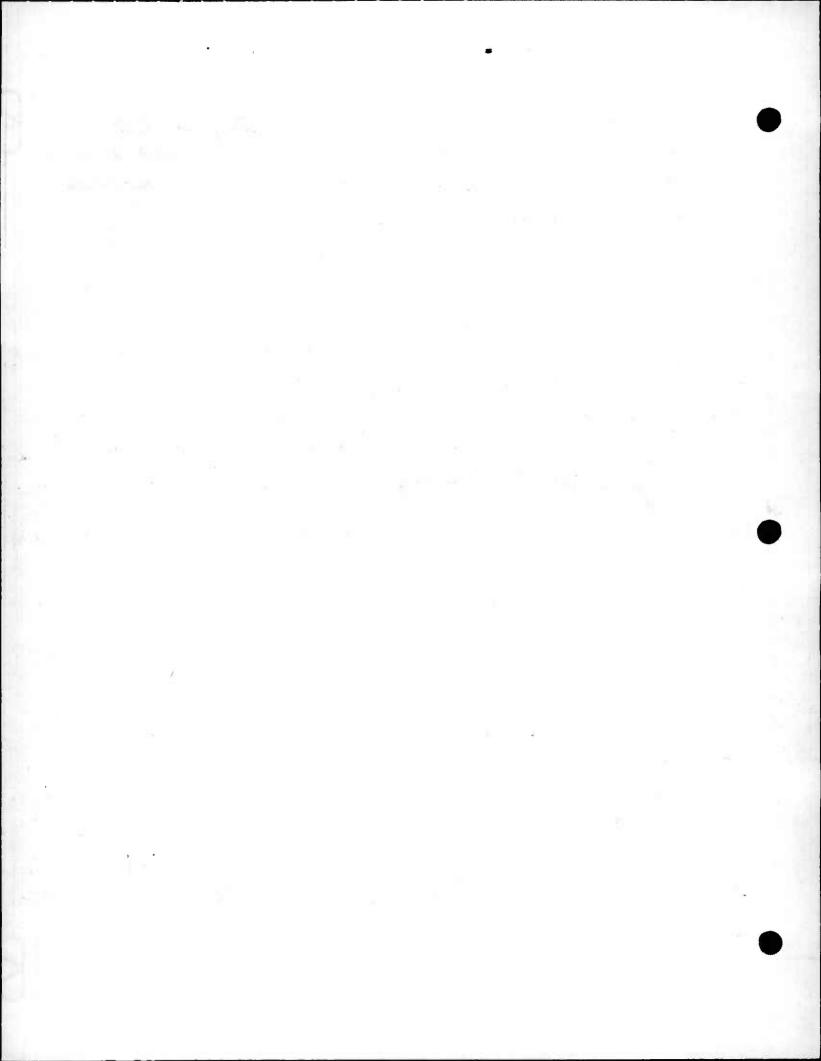
JACQUELYN ANN GERGEL 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 99. FACILITY NAME (If not institution, give street and number) 99. FACILITY NAME (If not institution, give street and number) 7396 Back St. RESIDENCE OF DECEDENT 100. CITY, TOWN OR LOCATION OF DEATH Newcomb 101. ZIP CODE 7396 Back St. 11. MARITAL STATUS 10. STATE 10. STATE 10. STATE 10. STATE 10. CITY, TOWN OR LOCATION Newcomb 101. ZIP CODE 7396 Back St. 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN If yes, specify Cuben, Maxican, Puerio E 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, A Middle, Last)	Ta 10g. CIT 10g. CIT 17 (Specify Yes or No—Rican, etc.)	6. BIRTHPLACE (State or Foreign Country) Ohio INTY OF DEATH A IDOT 10d. INSIDE CITY LIMITS? 1									
4. SOCIAL SECURITY NUMBER 280-34-1408 1	OF BIRTH 1, Day, Year) 1 15, 1938 9c. COU Ta 10g. Cit	6. BIRTHPLACE (State or Foreign Country) Ohio INTY OF DEATH A IDOT 10d. INSIDE CITY LIMITS? 1									
T396 Back St. RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY Newcomb 10c. CITY, TOWN OR LOCATION Newcomb 10e. STREET AND NUMBER 7396 Back St. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES YE	Ta 10g. CIT 10g. CIT 17 (Specify Yes or No—Rican, etc.)	10d. INSIDE CITY LIMITS? 1 YES 2 NO IZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, etc. Specify: White									
10e. STREET AND NUMBER 7396 Back St. 11. MARITAL STATUS 11. Never Merried 2 Merried 3 Wildowed 4 Olivorced 12. Was decedent ever in U.s. Armeo FORCES? 1 YES 2 NO If YES, GIVE WAR OR DATES 13. Was decendent of hispanic origin If yes, specify Cuben, Maxicen, Puerio F 1 YES 2 NO If YES 2 NO If YES, GIVE WAR OR DATES 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, A	17 (Specify Yes or No— Rican, etc.)	LIMITS? 1 YES 2 NO IZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, etc. Specify: White									
3 Widowed 4 Notwork of the Notward of Specify: 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) 12 16e. DECEDENT'S USUAL OCCUPATION (Ghe kind of working life. Do NOT use refreed.) Art Teacher 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, A	17 (Specify Yes or No— Rican, etc.)	U.S.A. 14. RACE — American Indian, Black, White, etc. Specify: White									
3 Widowed 4 Notworked IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) 12 7 16e. DECEDENT'S USUAL OCCUPATION (Glive kind of working fille. Do NOT use refired.) Art Teacher 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, A	Rican, atc.)	Specify: White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4 or 5+) 12 7 17. FATHER'S NAME (First, Middle, Last) William Ernst 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) Art Teacher 18. MOTHER'S NAME (First, A Middle, Last) Conceviouse	KIND OF BUSINESS/INC										
12 7 Art Teacher 18. Mother's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Middle, Middle, Middle, Middle, Middle, Middle, Middle, Middle, Middle, Middle, Middle, Middle, M	of work done during most of working T use retired.)										
William Ernst Genevieve	School										
		n Heestand									
19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Numb											
included A. Gerger 2200 Indiana Ave Columbu	Michael A. Gergel 2286 Indiana Ave Columbus, Ohio										
20e. METHOO OE DISPOSITION t Burlei 2\(\text{Disposition} \) Removal from State 4 Donation 5 Other (Specify) Capitol Crematory July 19, 1	20c. LOCATION – 995 Dover,	City or Town, State Delaware									
21. SHONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Harrison E. Leonard 312 S. Talbot St.											
23. PART i. Enter the diseases, or complication that caused the death. Do not enter the mode of dying, such as cerd shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):	lec or respiratory em	Approximate intervel Between Onset end Death 3 4 11mo									
Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.											
PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert i. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 26. PLACE OF DEATH (Check only one of the conditions) of the conditions	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	Y 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 1 YES 2 NO									
25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one	9)										
EXAMINER? 1 YES 2 NO HOSPITAL: OTHER: 4 Nursing Home 5 Residence 8 Other											
27. MANNER OF OEATH 280. OATE OF INJURY 1 Netural 5 Pending 280. OATE OF INJURY (Month, Day, Year) 280. TIME OF INJURY WORK? 1 YES 2 NO 28d. OEŞI	CRIBE HOW INJURY OCC	CUREO									
	28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the besis of exemination end/or investigation, in my opinion, desth occured at the time, date and place, end due to the caur											
296. SIGNATURE AND TITLE DECERTIFIER 296. LICENSE NUMBER 297. LICENSE NUMBER	29d. DATE	E SIGNED (Month, Day, Year)									
- Libert Wild Commenter of Centri (Hem 27) (1998, Print)	David H. Smith M.D. 509 Idlewild Ave. Easton, Maryland 21601 31. DATE FILEO (Month, Day, Year) 32. REGISTRANG SIGNATURE P										



FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

			1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH		3. T	IME OF DEATH
			Alberta Ha	ynes	George					6 19	795	750 P .
			4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. last	birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTHPLAC	CE (State or Foreign
	-		219-14-4979	1 🗆 M 2 🔀 F	88	YRS.	MONTHS DAYS	HOURS MIN.	August 1			
	ponic		9e. FACILITY NAME (If not institution, give	street end number)			9b. CITY, TOWN	OR LOCATION OF D			TY OF DEATH	
	2, 3 should	OR	Dorchester Ge	neral Ho	ospital		Camb	ridge		Do	rches	ster
	s 1.	5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT									
	ling physician. the burial-transit permit. Pages 1,	DIRECTOR		roline			rown on Loc Presto				10d	. INSIDE CITY LIMITS?
			10e. STREET AND NUMBER			4						YES 2 NO
		FUNERAL		3				O. 1. C. E. E.		10g. CITIZ	EN OF WNAT	COUNTRY?
	trans	N N	3755 Payne R	12. WAS DECEDENT	Y EVED IN U.C. 400	450		21655			SA	
320	physic		1 Never Merried 2 Merried	FORCES? 1	YES 2 N	0	If yes,	specify Cuban, Mexico	NIC ORIGIN? (Specify Youn, Puerto Ricen, etc.)	e or No—	Black, Wh	American Indian, ilte, etc.
5-0020	retained by the hospital or attending physician. 5 should be detached for use as the burial-tran totified at once.	В	3 Widowed 4 Divorced	IF YES, GIVE W	AH OH DATES		1 1 41	ES 2 NO Speci	ly:		Specify: Black	
218	attend se as		15. DECEDENT'S EDU (Specify only highest grade	CATION Completed	16a. DEC	EDENT'S L	USUAL OCCUPA	FION	16b. KIND OF BI	JSINESS/INDU		'K
21	al or atte	<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5 +	- Ma	Do NOT use	ork done during in retired.)	nost of working				
ND	the hospita detached once.	COMPLETED	7		Pro	ces	sing-1	ineHelp	er Poul	trv I	ndus	trv
A	detach	8	17. FATHER'S NAME (First, Middle, Last)						ME (First, Middle, Maide			
₹	a 5 5	BE (George Havne	S SR.			_	Eliza	beth Co	vingo	dale	
MARYLA	5 should notified	0	19e. INFORMANT'S NAME (Type/Print)		19b	MAILING	ADDRESS (Stree	t end Number or Rural	Route Number, City or To	wn, Stata, Zip (Code)	
		-	Oscar George		80)3 Pa	ark La	ne Camb	ridge Ma	rvlan	d_21	613
R	e 6 may ector, pa must b		20e. METHOD OF DISPOSITION 1 № Burlet 2 □ Cremation 3 □ Rem	noval from State	20b. PLACE A cemetery, cren	ND DATE O	F DISPOSITION /	Name of	DATE 20c. L	OCATION — C	Ity or Town, S	State
8	funeral director, xaminer must		4 Donetion 5 Other (Specify)		Jones	town	1 Ceme		17/20 P	resto	n.Mar	vland
Ē	dearn. Pag tuneral dii I. examiner		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	01	2		AND ADDRESS OF FA	VCILITY		- 1	
BALTIMOR	9 -	3	Janelle	C, 8	Henr	4	510W	ry rune. ashinata	ral Home on St.Car	nhrid	co Ma	ryland
ш	d in by the or removal medical		23. PART . Entar the diseases, or	complications that	csused the dea	ith. Do no	ot anter the m	node of dying, suc	th ea cardiec or reas	iretory erre	st.	Approximate
de .			V shock, or heart failure. IMMEDIATE CAUSE (Finel	List only one caus	se on each line.							Intervel Between Onset and Death
			disease or condition resulting in death)	Kan	crea	fic	Ca	ncor			i	1 Mont
99	completely fill ial, cremation; event, the	- 1	resulting in death)		OR AS A CONSEO			((2)			 i	t illoutt
68760		z	***************************************	b.								
XO	or physician and c giene prior to buria other traumatic	CERTIFICATION	Sequentially list conditions, if any, leeding to immediate	DUE TO (OR AS A CONSEO	UENCE OF)):					
BC	physician ne prior tr	2	CAUSE (Disease or Injury	c								
0	ueaur ceruncate s attending physi ental Hygiene pri	ËΙ	thet initiated events resulting in death) LAST	DUE TO (OR AS A CONSEO	UENCE OF)):					
Δ.	attending mtal Hygie		d									
	을 후 후 를	. 11	PART II. Other significent condition	ns contributing to	death but not re	suiting in	the underlyl	ng ceuse given in	Pert t. 24e. WAS AI			E AUTOPSY FINDINGS
CORD	ed by	MEDICAL							PERFO	RMED?	COM	LABLE PRIOR TO PLETION OF CAUSE
Ü.	equires trait en signed by of Health an thows any									A NO		YES 2 NO
4	- 0 , 60	11	DID TOBACCO USE CONT	RIBUTE TO CAI	USE OF DEAT	H YES	S 🗆 NO [UNCERTAI	NΠ			123 1
A.	item 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				(Check only one					
VITAL	certificate has been the State Dept. of I, or Item 23 sho	Si	1 YES 2 NO	HOSPITAL:	ER/Outpatient 3		OTHER: 4 Nursing Ho	me 5 🗆 Residence	8 Other (Specify)			
11.	this cert with the	PHY	27. MANNER OF DEATH	28e. DATE OF I		28b. TIME	OF 28c. II	JURY AT	28d. DESCRIBE HOW	INJURY OCCU	RED	
0	fter this cath with marked	8	1 Natural 5 Pending 2 Accident Investigation	(WORL), DE	y, rear)	muu		ORK? YES 2 NO				- 1
0	R: After 1 r death is mar		3 Suicide 6 Could not be	28e. PLACE OF	INJURY — A1 hon	ie, 1erm, st	reet, factory, off	Ice	281. LOCATION (Street	and Number o	r Rural Route	Number,
DIVISION	DIRECTOR: After hours after death		4 Homicide determined		(4,550.))				City or Town, State	7		
5 5	the man	٦ [29e. CERTIFIER (Check only	ICIAN: To the best of r	my knowledge, dea	th occurred	d at the time, da	te end place, end due	to the cause(s) end me	nner es states	1.	
i di	THE FUNERAL fled within 72 PORTANT: It	COMPLET	one) 2 MEDICAL EXAMINE									manner es stated.
	FUNER Within	S I	296. SIGNATURE AND TITLE OF CERTIFIE					29c, LICENSE NUI			SINED (Mon	to the second second
i	TO THE FUNERAL TO THE FUNERAL De filed within 72 IMPORTANT: II	œ	William	Ban	, m	D		1)432	138	▶ 7	16	9
1	= E 5 =	임	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	E OF DEATH (ITEM	27) (Type, I	Print) [[((1	<u> </u>
			William	Dair	19		encli	n St.	Cam	brid	9e, 1	no 21613
			31. DATE FILED (Month, Day, Year)	32. REGISTRAF	R'S SIGNATURE				- 011			
	2		JUL1 8 1995	Jalia other	WE SIGNATURE	Ц						



funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should filled in by the filon, or removal. ŏ cremation. and completely 1 burial, crematio and Hygiene prior to physician the attending p s been signed by the 23 shows any Dept. certificate has b

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other traumatic event,

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CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BH

2

1 Natural

2 Accident 3 Suicide

4 Homicide

Tem I

the

this c

TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If item 2

DIRECTOR: After this cenhours after death with this item 28 is marked, o

95 23 19 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 9 1DDINS 4. SOCIAL SECURITY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) (Month, Day, Yea 5/29/25 1 X M 2 7 F 229-36-4956 VÃ 9e. FACILITY NAME (If not institution, gir 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DUTHERN HOSPITAL LINTON PRINCE GRONGES RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Prince Georges Temple Hills, MD 1 X YES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 4111 24th Avenue 20748 USA 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or Noif yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 X Merried IF YES. GIVE WAR OR DATES 1 TES 2 NO Specify: 3 Widowed 4 Divorced Specify WWII Black 15. DECEOENT'S EDUCATION 18e. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highes Elementary/Secondary (0-12) College (1-4 or 5+) 10th Groundskeeper Maintenance 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Stanley Giddins Mackie Harmon 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Jerry Giddins 4111 24th Avenue, Temple Hills, MD 20748 20s METHOD OF DISPOSITION
1 C Burisl 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State Ebenezer Baptist 7/22 Wardtown, VA 21. SIGNATURETOF FURERAL BE 22. NAME AND ADDRESS OF FACILITY
C.C. Humbles Funeral Service 0. Box 176, Accomac, VA 23301 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or haart failure. List only one causa on each line. Intarvai Batween IMMEDIATE CAUSE (Final **Onset and Death** disease or condition reaulting in death) DUE TO (OR AS A CONSEQUENCE OF Sequantially list conditions, OUE TO (OR AS A CONSEQUENCE OF) if any, laading to immediata cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF) reaulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Partyl 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO

1 YES 2 NO

DID TOBACCÓ USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO UNCERTAIN 🔲

25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)

HOSPITAL: 1 TES 2 PNO 1 Phopatient 2 ER/Outpatient 3 DOA 27. MANNER OF GEATH

8 Could not be

29b. SIGNATURE AND TITLE OF CERTIFIER

OTHER 28e, OATE OF INJURY

4 Nursing Home 5 Residence 8 Other (Specify) 28b. TIME OF INJURY 28c. INJURY AT WORK?

1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify)

28d, DESCRIBE HOW INJURY OCCURED

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the beet of my knowledge, death occurred at the time, date and piecs, and due to the cause(e) and manner es stated.

ination end/or investigation, in my opinion, death occurad at the time, date end piece, and due to the cause(e) and manner se stated.

Confo	alund my	
. NAME AND ADORESS O	F PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, P	rint

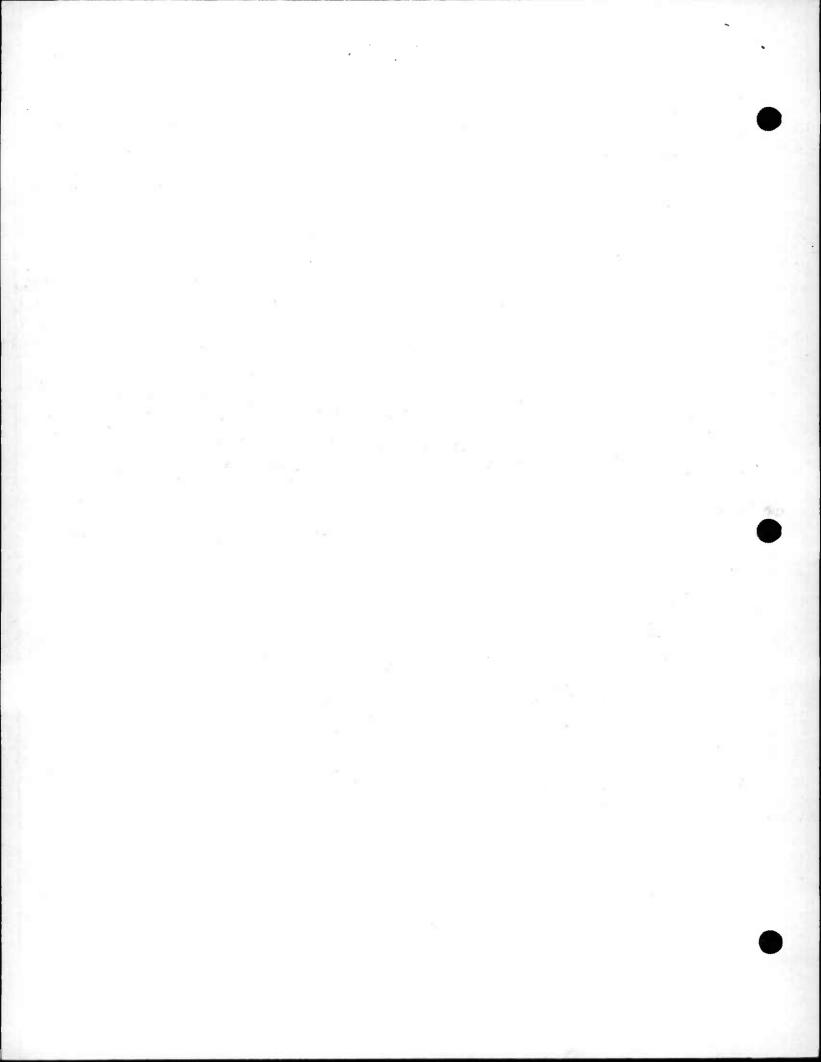
29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year) 5

30 1900

DHMH-16 Rev 1/89

20735



permit. use as the burial-transit Page 6 may be retained by the hospital or attending physician. for funeral director, page 5 should be detached filled in by the fi completely signed by the attending physician and con Health and Mental Hygiene prior to burial, 5 has b. Dept. 23 si certificate to the State this c After 1

BALTI Hours after death. P executed with OR ATTENDING PHYSICIAN; The

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Pages 1, 2, 3 s DIRECTOR: after 28 i hours HDSPITAL

BALTIMORE, MARYLAND 21215-0020

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JAMES EDWARD GODBOLD JULY Ï 995 SR 9 1405 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. (Month, Day, Yell Feb 9, DAYS 217-30-0272 1 🔯 M 2 🗌 F 61 HOURS YRS Wash DC 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MEMORIAL HOSPITAL PRINCE FREDERICK CALVERT RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Calvert. Huntingtown 1 TYES 2 1 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1960 Lower Marlboro Road 20639 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexican, Pueno Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 🛣 NO 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 TYES 2 X NO Specify: BY Specify: 3 Widowed 4 M Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16h KIND OF BUSINESS/INDUSTRY (Specify Elementary/Secondary (0-12) College (1-4 or 5+) 1 Police Officer P.G. County Gov't once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Ħ Albert Herman Colvin Maud Godbold 띪 notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 R. Duane Godbold 929 Nichols Dr. Laurel, MD 20707 pe 20e. METHOO OF DISPOSITION
1 □ Burlel 2 🗷 Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must cemetery, cremetory or other place)
Metropolitan Crematory 7-14-95 4 Donation 5 D Other (Specify) Alexandria, VA examiner 21. SIGNATURE OF UNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, PA Owings, MD 20736 medicai 23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or reepiratory srrest, ehock, or heart failure. List only one cause on each line. Approximete intarvai Between IMMEDIATE CAUSE (Finsi Onset and Death the disease or condition STABE CHRONIC OBSTRUCTING PULMONARY DISPASE . LND resulting in death) YEAR event. OUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION traumatic Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) If sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST 10 PART ii. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. MEDICAL 24s. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 1 TYES 2 NO Shows 1 TES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) FYAMINER? HOSPITAL: OTHER: 1 YES 2 NO Vinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 0 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Accident 5 Pending triveatigation М 1 YES 2 NO BY 26a. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) .09 ETED 6 Could not be 4 Homicide determined CERTIFYING PHYSICIAN. To the best of my knowledge, death occurred at the time, data end piece, end due to the cause(e) end menner as stated. COMPL TO THE HOSPITAL TO THE FUNERAL DE filed within 72 h 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

PRINCE FREDERICK, MARYLAND

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JOHN

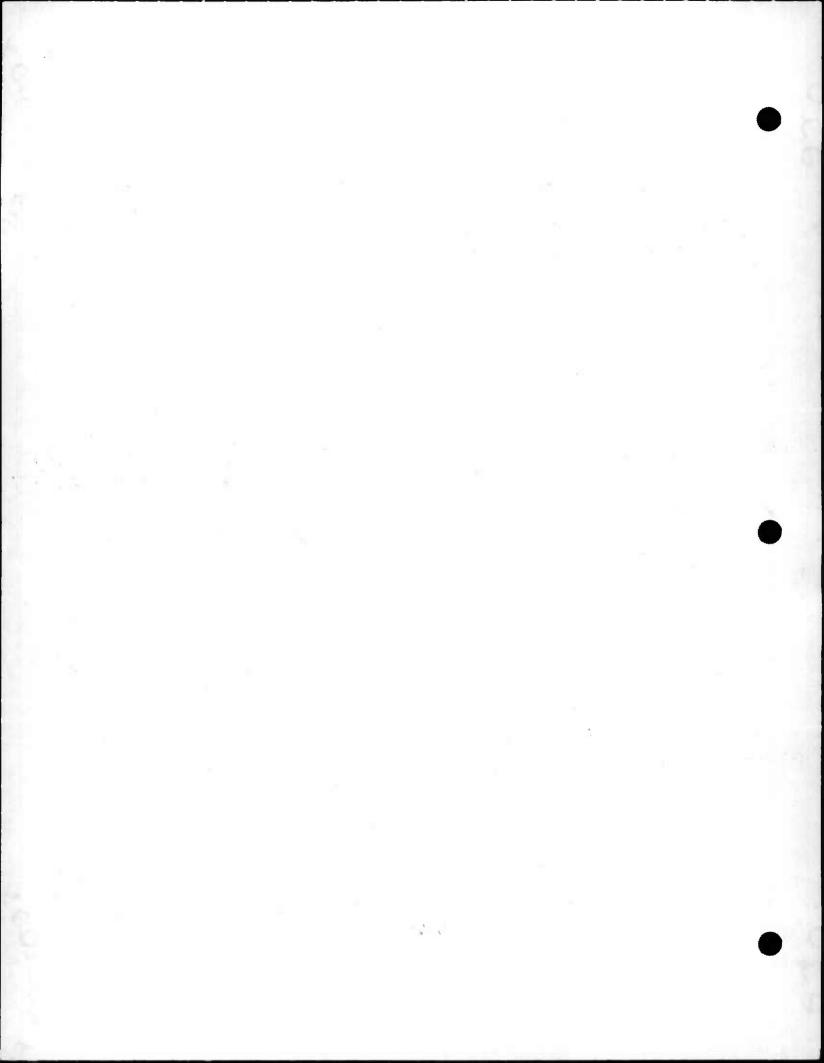
31. DATE/FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

22. REGISTRAR'S SIGNATURE

WEIGEL

1995



mit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: Atter be filed within 72 hours after death

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Ray 4. SOCIAL SECURITY NUMBER 577 12 5873 9a. FACILITY NAME (If not institution, give si Calvert Memoria RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Calv 10a. STREET AND NUMBER	5. SEX 1 2 M 2 D F Irrect and number) al Hospit	AGE (In yrs. les	t birthday)	IF UNDER	1 VEAR			MONTH D	AY	YEAR		\neg
4. SOCIAL SECURITY NUMBER 577 12 5873 9a. FACILITY NAME (If not institution, give si Calvert Memoria RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Calv 10c. STREET AND NUMBER	5. SEX 1 2 M 2 D F Irrect and number) al Hospit	AGE (In yrs. les	t birthday)	IF UNDER	1 VEAR		- 1	T 7 7				- 1
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Calvert Memoria RESIDENCE OF DECEDENT 10a. STATE Maryland Calv 10a. STREET AND NUMBER	al Hospi	ta1	M 2 F 77 YRS. MONTHS DAYS HOURS MIN. F CONTROL CONTROL						2,1	B CAMPA	PLACE (State or Foreign St Virgi	n
Maryland Calv			of and number) 1 Hospital 9b. CITY, TOWN OR LOCATION OF DEATH Prince Frederick 9c. COUNTY OF D Calves									
10e. STREET AND NUMBER												=
											10d. INSIDE CITY LIMITS? 1 YES 2 NO	Н
1920 Matapeal	ce Court					ZIP CODE					HAT COUNTRY?	
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT, E FORCES? 12 IF YES, GIYE WAR	YES 2 N		- 1	If yes, sp	ecify Cuban	, Mexican.	C ORIGIN? (Specify Yes Puerto Rican, etc.)				
			CEDENT'S	IIGUAL O	CCLIBATIO	M		Tel Vivo or But				4
		ille.	Do NOT us	e retired.)	during mo	st of working	'					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) Glover Gum College (1-4 or 5+) Glover Gum College (1-4 or 5+) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of working most of working life. Do NOT use relired.) Union plumber Construction 16. MOTHER'S NAME (First, Middle, Maiden Surmame) Ethel Kettle												
19a. INFORMANT'S NAME (Type/Print) 19b. MAJLING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20685 1920 Matapeake Ct. St. Leonard Maryland												
20a. METHOD Q5 DISPOSITION 1 Dariel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Cample of C												
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.												
IMMEDIATE CAUSE (Final disease or condition	DIATE CAUSE (Final										Interval Between	
DUE TO (OR AS A CONSEQUENCE OF):												
Sequentially list conditions, if any, leading to immediate cause Enter LINDERLYING	equentially list conditions, any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
CAUSE (Disease or Injury that Initiated evente resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions	contributing to de	eth but not re	aultina i	the un	dagivino	cours of	van In Be	m 1 04- 440 Au	ALCTORAL	1		耳
PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?											1	
DID TOBACCO USE CONTR	RIBUTE TO CAUS	E OF DEAT	ГН ҮЕ	1 🗆 2	40 🗆	UNCE	RTAIN				T TES Z NO	1
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL	28. PLACE	OF DEAT									
1 TYES 2 THO	1 Inpatient 2 - EF			4 🗌 Nun		5 🗆 Resi	idence 8	Other (Specify)				
Natural 5 Pending		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED									7	
3 Suicide 8 Could not be determined	28s. PLACE OF IN building, atc.	IJURY — At hon (Specify)	ne, farm, si	raet, fact	ory, office		2	8f. LOCATION (Street a City or Town, State)	nd Number	or Rural Re	oute Number,	٦
											and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER William M	. ml	Rell	2	_		29c. LICEN	SE NUMBE	ER	29d. DATI	SIGNED	(Month, Day, Year)	\dashv
	3 Widowed 4 Divorced 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last) Glover Gur 19a. INFORMANT'S NAME (Type/Print) Michael Gumm 20a. METHOD Q6 DISPOSITION 1 Burlel 2 Gremation 3 Remark 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE 23. PART I. Enter the diseases, or condition resulting in death) Sequentially list conditions, if any, leading to immediate couse. Enter UNDERLYING CAUSE (Plosese or Injury that initiated evente resulting in death) LAST PART II. Other algnificant conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Netural 5 Pending investigation 3 Suicide 8 Could not be determined 4 Hemicide 8 Could not be determined 29a. CERTIFIER (Check only 1 DERTIFYING PHYSIC (Check only 2 MEDICAL EXAMINER) 29b. SIGNATURE AND TITLE OF CERTIFIER WALLE MEDICAL EXAMINER	Sequentially list conditions, if any, leading to immediate ceause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST Sequentially in death) LAST DID TOBACCO USE CONTRIBUTE TO CAUSE (Standard evente resulting in death) LAST Pending investigation 28a. DATE OF INJURE (Check only one) 2 MEDICAL EXAMINER: On the basis of examiner. Medical examiner. Medic	3 TWidowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DE (Grant Middle, Last) 17. FATHER'S NAME (First, Middle, Last) Glover Gum 19a. INFORMANT'S NAME (Type/Print) Michael Gumm 19a. INFORMANT'S NAME (Type/Print) Michael Gumm 19a. INFORMANT'S NAME (Type/Print) Michael Gumm 19a. INFORMANT'S NAME (Type/Print) Michael Gumm 19a. INFORMANT'S NAME (Type/Print) Michael Gumm 19a. INFORMANT'S NAME (Type/Print) Michael Gumm 19a. INFORMANT'S NAME (Type/Print) Michael Gumm 19a. INFORMANT'S NAME (Type/Print) Michael Gumm 19a. INFORMANT'S NAME (Type/Print) Metro 20a. Metroo Gumm 19a. INFORMANT'S NAME (Type/Print) Metro 21. SIGNATURE OF FUNERAL SERVICE LICENSEE DUE TO (OR AS A CONSECTION OF THE TYPE	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that Initiated evente resulting in death) LAST DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH Sea Consecuence of Cause (Check only 1 Death 1 Did Tobacco USE Contribution contributing to death but not resulting in Method to the building, atc. (Specify) Signature of Death Signature of Deat	Newer Married 2 Married Newer Married 2 Married Newer Man of DATES	Nover Married Divorced PONCEST PL YES 2 No If yes, spi 1 YES 3 Nover Married 1 Nov	S. DECEDENT'S EDUCATION PYES, GIVE WAY OF DATE 19	New York Married 2 Married PYES, GIYE WAI OF DATES 1 Yes, specify Cubbin, Markican, 1 Yes \$2 NO Secochy	Sequentially list conditions and contributing to deeth but not resulting in the underlying cause given in Part I.	Type Married Married Married Process Policies Polici	Types, specify Calebra, Marken, Parker Rican, etc.) Section	Type, specify Colours, Marketan, Partire Rich, etc. Specify Will te Specify Wi

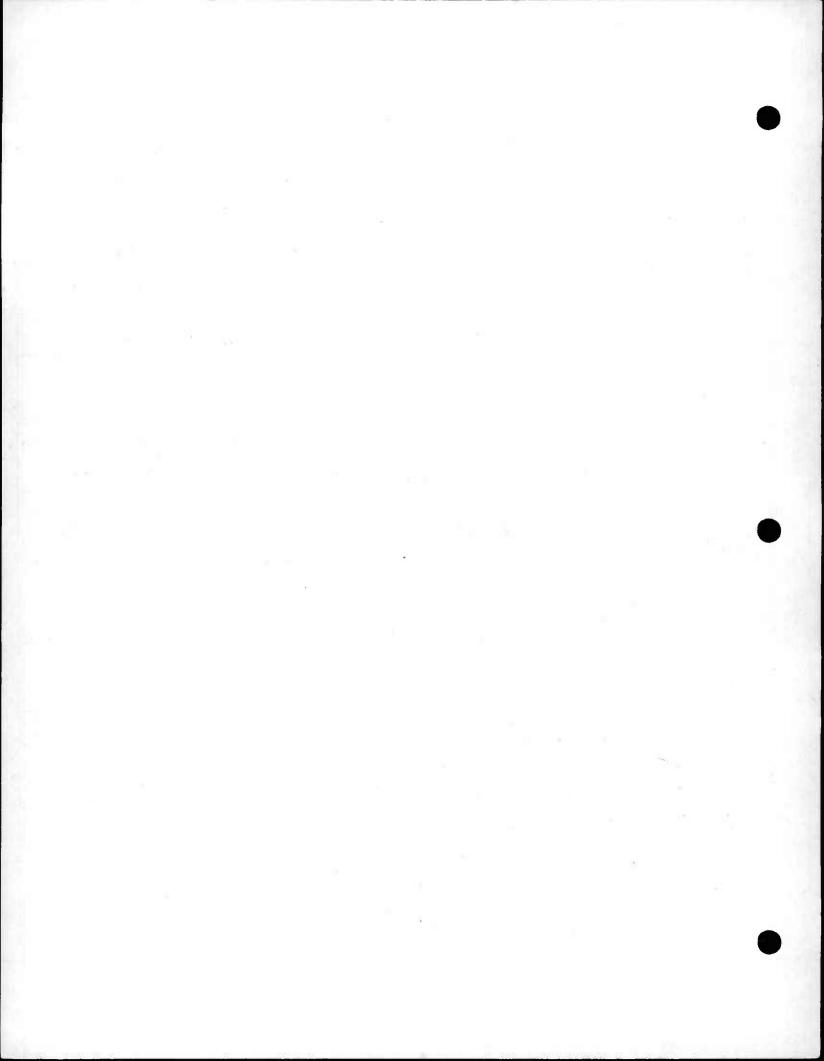
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE MOSPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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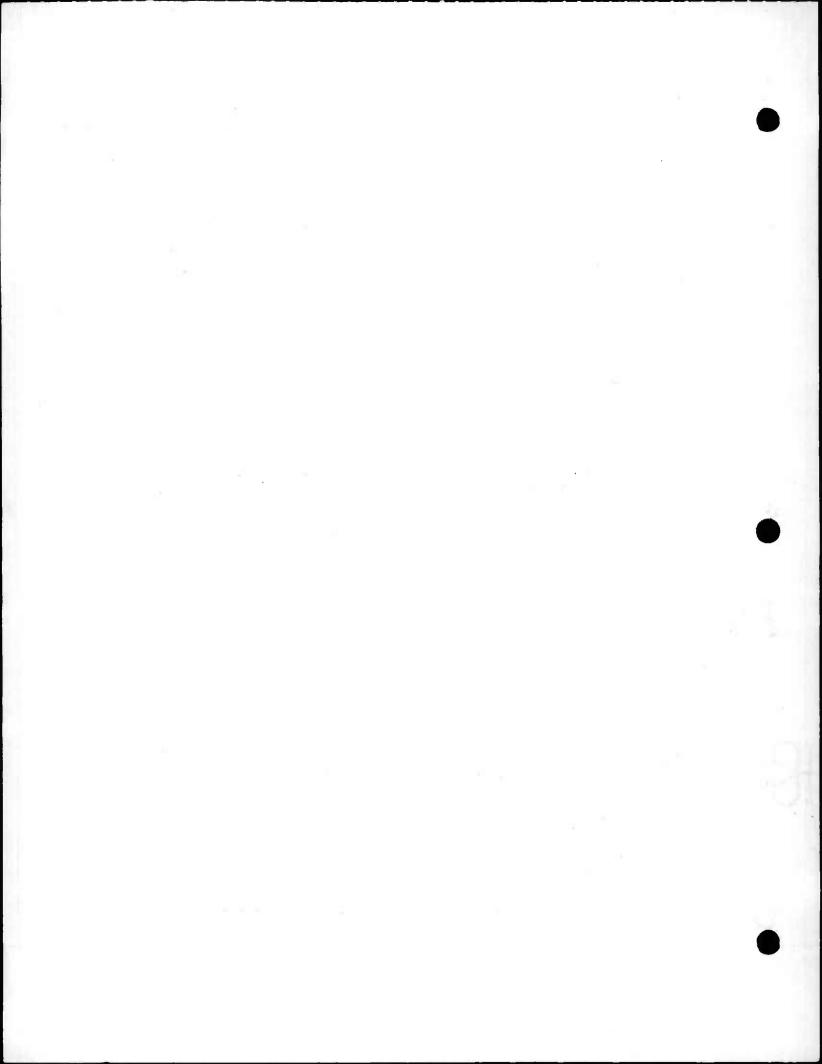
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	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEP	PARTMENT OF I	HEALTH AND	MENTAL HYGIEN							
1	1. DECEDENT'S NAME (First, Middle, Last)					2, DATE OF DEATH			3. TIME OF DEATH				
	VIRGIL MILTO	ON GRAHAM	JR.			MONTH D	AY 1.O	YEAR	120				
	4. SOCIAL SECURITY NUMBER	0.44.4.1		(ma) I I I I I I I I I I I I I I I I I I I		JULY 1	8 TA	95	PLACE (State or Foreign				
	MONTHS DAYS MOUNT MONTHS DAYS MIN. (Month, Dey, Year)												
	173-18-7391		75 YR			MARCH 13,	1920	PENN	SYLVANIA				
	9a. FACILITY NAME (If not institution, give s			9b. CITY, TOWN	OR LOCATION OF DI	EATH	9c. COUN	c. COUNTY OF DEATH					
DIRECTOR	616 MARYLAND AVE	INUE			HAGERSTO	WN	HINGTON						
E E	10a. STATE 10b. COUNT	Y	10c.	CITY, TOWN OR LOCA	TION				10d. INSIDE CITY				
ā	MARYLAND	WASHINGTON		HAGE	RSTOWN				LIMITS? 1 X YES 2 NO				
٦	10e. STREET AND NUMBER	10e. STREET AND NUMBER 10f. ZIP CODE							HAT COUNTRY?				
FUNERAL	616 MARYLAND AVE	2174	40		·S·A								
5	11. MARITAL STATUS	12. WAS DECEDENT EVER I	IN U.S. ARMED	13. WAS DE	CENDENT OF HISPAN	NIC ORIGIN? (Specify Yes	or No-	14. RACE	- American Indian, White, atc.				
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	DATES		Secify Cuban, Maxica 2 NO Specify	nn, Puarto Rican, etc.) y:		Specify	y:				
0	15. DECEDENT'S EDU			IT'S USUAL OCCUPATI		Million Waller			WHITE				
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ן בֶּן	Elamentary/Secondary (0-12)	College (1-4 or 5+)											
Σ	11		N	MAINTENANC	E	TRUCK	MANUE	'ACT'U	JRING				
COMPL	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden	Sumame)						
ш	VIRGIL M. GRAHAM	SR.			FERN NI	CKLO							
0 8	19a. INFORMANT'S NAME (Type/Print)		19b. MAIL	ING ADDRESS (Street		Route Number, City or Tow	n. State. Zip	Code)					
	OLIVE H. GRAHAM					AGERSTOWN,			21740				
	20a. METHOD OF DISPOSITION	200	b. PLACE AND DA	TEOEDISPOSITION /N	ame of	Y	CATION - C						
. 1	1 X Burlal 2 Cremation 3 Removal from State Completery, crematory or other place MT 2 ION CEMETERY 7/21/95 SAN MAR, MARYLAND												
	21. SIGNATURE OF FUNERAL SERVICE AT		20 0101		ND ADDRESS OF FA	CILITY							
	h) and a	Daul	M. Dea		UNERAL H	7606	Old N	Vatio	nal Pike				
	Taul MIN	av rau	M. Dea	ui BASI r	UNERAL H	Boons							
	23. PART I. Enter the disesses, pr	complications that causa	d tha death. D	D not antar the me	da of dving, suc				Approximata				
	shock, or heart failura. List only one cause on each line.												
	IMMEDIATE CAUSE (Final disease or condition												
	reaulting in daath)	a. CARCINO	MATO	515					4 YEMAY				
	DUE TO (OR AS A CONSEQUENCE OF):												
z	CANCINOMA OF CULON 4 YEARS												
CERTIFICATION	Sequentially list conditions, If sny, leading to immediata DUE TO (OR AS A CONSEQUENCE OF):												
8	cause. Entar UNDERLYING												
Ĕ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE	E OF):									
E	resulting in death) LAST												
8		d							-				
II	PART II. Other algolificant condition	a contributing to death b	out not rasultion	ng in the underlyin	g causa given in	Part I. 24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS				
2	Nons					PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE				
						1 YES 2	Z-NO		OF DEATH?				
Σ									1 YES 2 NO				
ä	DID TOBACCO USE CONT	RIBUTE TO CAUSE C	BUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
× I	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF D	DEATH (Check only one)									
S	1 YES 2 4 NO	HOSPITAL: 1 Inpatient 2 ER/Out	petient 3 DO	OTHER:	e 5 A Raeldenca	a							
PHYSICIAN: MEDICAL	27. MANNER OF DEATH	28a. DATE OF INJURY		- Consisting from	URY AT	28d. DESCRIBE HOW I	Million occ	UDER					
<u>a</u>	1 Natural 5 Pending	(Month, Day, Year)	_	INJURY WO	PRK?	200. DESCRIBE HOW I	NJUNT OCC	UNED					
B	3 Suicide 6 Could not be 28a. PLACE OF INJURY — At home, farm, street, factory, office 26f. LOCATION (Street and Number or Rural Route Number,												
	O Codiu not be	4 Homicide detarmined building, atc. (Specify)											
	O Codiu not be				29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.								
	4 Homicide detarmined		dados dosth co-	numed at the time of a	and alone and a								
	4 Homicide detarmined 29a. CERTIFIER (Check only	CIAN: To the beat of my know											
	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my know R: On the basis of axaminatio							and manner as stated.				
COMPLETED	4 Homicide detarmined 29a. CERTIFIER (Check only	CIAN: To the best of my know R: On the basis of axaminatio			eath occured at the	time, data and placa, an	d due to the	cause(s)	and manner as stated. Month, Day, Year)				
	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my know R: On the basis of axaminatio			leath occured at the	time, data and placa, an	d due to the	signed (

MD, 21742



use as the burial-transit permit. Pages 1, 2, 3 should hospital or attending physician. Ď by the hospital be detached for director, removal. 5 cremation, and completely f burial, crematio

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DIVISION OF VITAL RECORDS, P.O. BOX 68760 🔏 BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withment hours after death. Page 6 may be retained by the hospital or attending physics
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be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBBINS

Jahr dieser well on the

95 23 195 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Edwin GLOVER 95 Lawrence 2050 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7 DATE OF BIRTH 8. BIRTHPLACE (State or Foreign West Virginia March 6,1919 214-09-9843 1 🔯 M 2 🗌 F 76 YRS. HOURS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington County Hospital Hagerstown Washington RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10h COUNTY 10d. INSIDE CITY Maryland Washington Hagerstown 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21742 33 Laurel Street U.S.A. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Maxican, Puerto Rican, atc.)

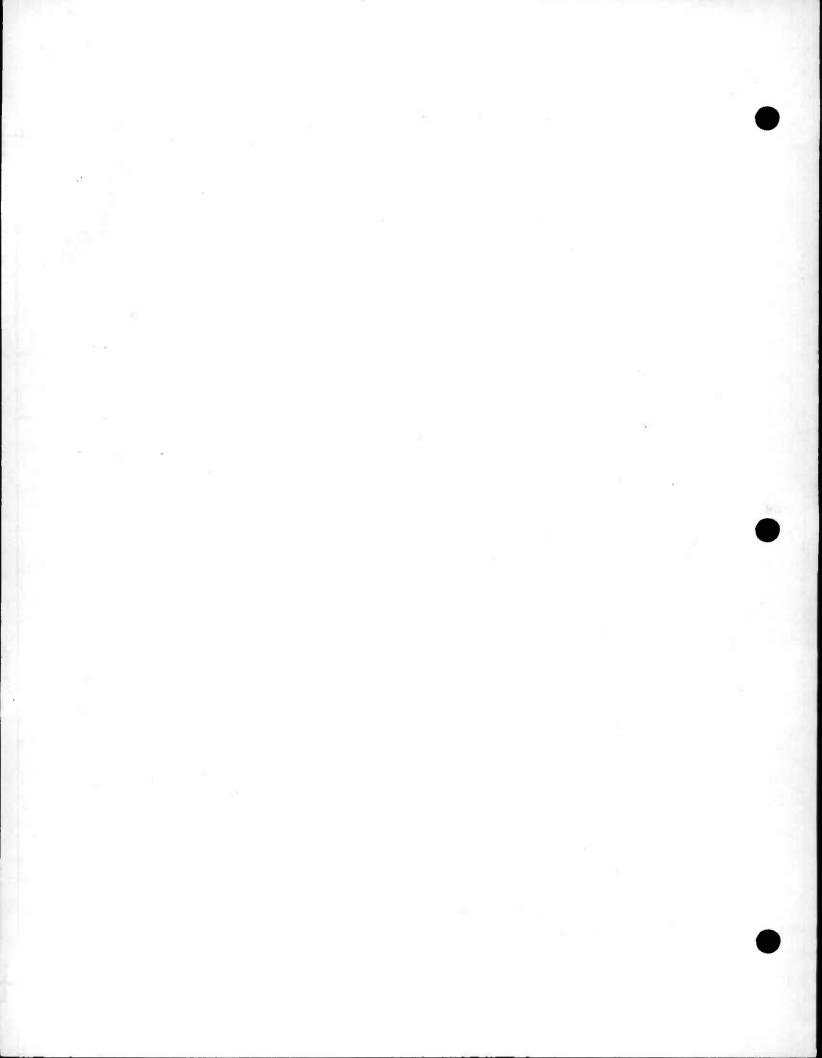
1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 NO 14. RACE - American Indian, Black, White, atc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES Specify: white BY 3 Widowed 4 Divorced COMPLETED 18e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION 16h KINO OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 0 - 121 - 4marketing agent fruit growing once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) To Edwin Glover, Sr. Virginia LeDane Lawrence BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 33 Laurel Street, Hagerstown, Maryland Mrs. Mary Glover 21740 9 20a. METHOD OF DISPOSITION
1 ☑ Buriel 2 ☐ Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Spring Mills Cemetery 7+22-95 Spring Mills, WV 4 Donation 8 Other (Specify) _ examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, MD 21740 full -Westel medicai 23. PART I. Enter the disesses, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. intarvai Between **IMMEDIATE CAUSE (Final** Onset and Death other traumatic event, the diseese or condition_ CARDIAC ARREST resulting in death) DUE TO (OR AS A CONSEQUENCE OF): POSSIBLE 8EPS1S CERTIFICATION one work Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING ADULT RESPIRATORY DISTRESS SYNDROWS Buos CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST 0 in lary, PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? shows any CARCINOMA LARYNX 1 TYES 2 THO GANGRENE RIGHT COLON 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL:
110 Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO ВҰ Investigation 2 Accident 28a. PLACE OF INJURY — At home, ferm, street, tactory, office building, stc. (Specify) 3 Sulcide 2 6 Could not be 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYINO PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurse at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

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F VITAL RECORDS, P.O. BOX 68760	ICIAN: The law requires that the death certificate be executed with
OF VITAL RECORDS, P.O. BOX 68760	YSICIAN: The law requires that the death certificate be executed with
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withhere frours after death. Page 6 may be retained by the hospital or attending physician.

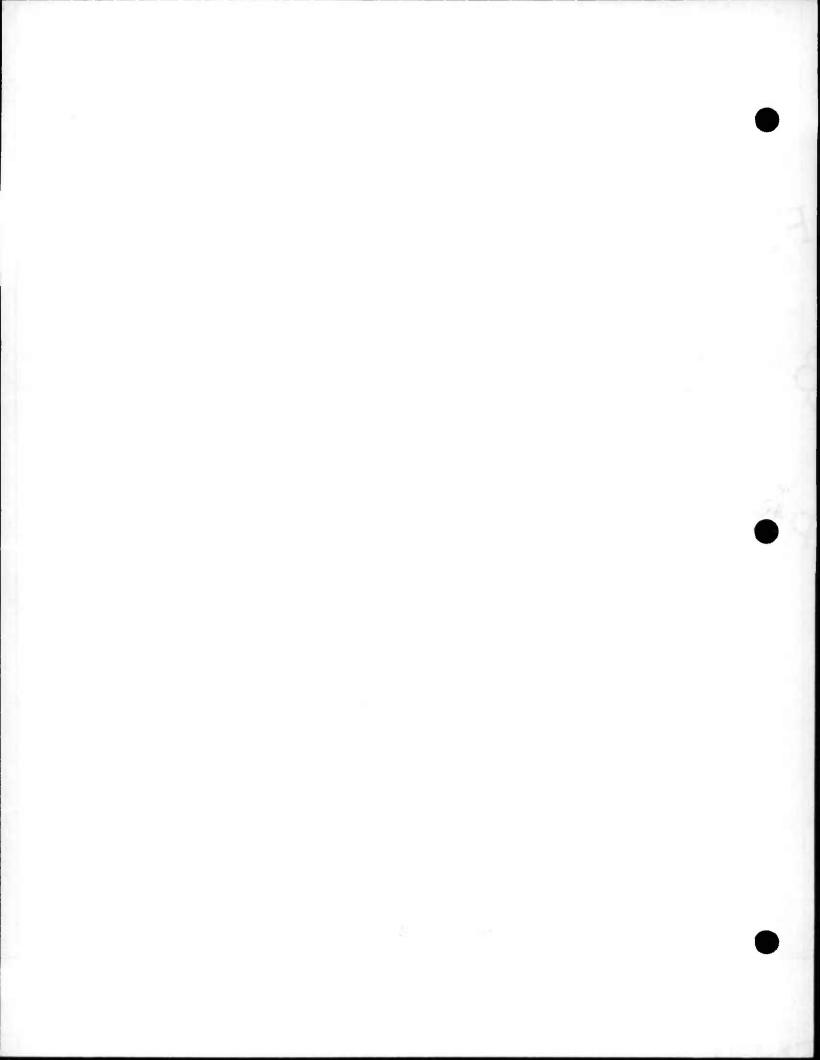
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Date 1995)

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	FOR STATE REGISTRAR	STATE OF MARY		EPARTMEN RTIFICAT				MENTAL HYG				
9	1. OECEDENT'S NAME (First, Middle, Lest)							2. DATE OF DEAT	ГН		3. TIME OF DEATH	
- 31	Jeanette E. Hayden								4 DAY	YEAR TQQ5	3:00 A.M. M	
	4. SOCIAL SECURITY NUMBER		E (In yrs. last b	irthday) IF UND	hday) IF UNDER 1 YEAR IF UNDER 24 HRS.			7. DATE OF BIRTH 6 BIRT			HPLACE (State or Foreign	
14.	428 32 8747	1 M 2 F	69		MONTHS DAYS MOVING MAN			(Month, Day, Ye	try)			
	9a. FACILITY NAME (If not institution, give a	Δ.	09	1557				Oct. 11	sissippi			
œ						OR LOCATIO	ON OF DE	EATH	90. 0	COUNTY OF	Y OF DEATH	
0	1507 Carlyle Drive Crofton Anne Arund											
DIRECTOR	44-07475											
Ē	(1)					ION					10d. INSIDE CITY LIMITS?	
100	Maryland Anne		Crof							1 ☐ YES 241 NO		
FUNERAL	10e. STREET AND NUMBER				10	. ZIP CODE			10g.	CITIZEN OF	WHAT COUNTRY?	
	1507 Carlyle Dr	ive				211	14		U	nited	States	
5	11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARME	D 13	. WAS DEC	ENDENT OF	F HISPAN	IIC ORIGIN? (Specif	y Yea or No		E — American Indian,	
	1 Never Married 2 Married	FORCES? 1 YE	DATES		If yea, ap	ecity Cubar	ı, Maxica	n, Puarto Rican, ato	1.)	Blac		
B	3 Widowed 4 Divorced	201100 10000			1 1 124	27.7.10	Specify	·.		Spec	White	
	15. DECEOENT'S EDU	CATION	16a. DECE	DENT'S USUAL	OCCUPATI	ON		16b, KIND O	F BUSINESS	INDUSTRY		
	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done NOT use retired	during mo	est of working	9					
3 1	Elementary/Secondary (0-12)	College (1-4 or 5+)						1 5		1		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	1	1 5	ecretar	У				ailro			
8						16. MOTH	ER'S NA	ME (First, Middle, Mi	elden Surnan	ne)		
8	Herbert Ezelle					Pe	ar1	Easom				
2	19a. INFORMANT'S NAME (Type/Print)		19b, A	MAILING ADDRE	SS (Street a	nd Number	or Rural I	Poute Number, City o	r Town, State	, Zip Code)		
	Leon C. Hayden		150	07 Car1	vle '	Drive	Cı	rofton M	d. 2	1114		
	206 METHOD OF DISPOSITION 206 PLACE AND DATE OF DISPOSITION (Name of											
- 1	Type Buriar 2 Cremation 3 Li Hemoval from State Cametery crematory or other place)											
- 1	i naryland vecerans cemetery //1//95 crownsville nd.											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A.											
	howert C.	CIMMA	the					lis Rd.				
	23. PART i. Enter the diseases, or o	complications that caus	ad the deat	h. Do not anti	r the mo	de of dvir	apu.	LIS INU.	DOWLE	riu .	Approximate	
- 1	shock, or haart fallure.	List only one cause on	each lina.			du or dyn	ig, auci	THE CEIGIAC OF I	ambinacory	arrust,	Interval Between	
	IMMEDIATE CAUSE (Final disease or condition	/	0								Onset and Death	
	resulting in death)	· Lune	a Cle	neer								
1		DUE TO (OR A)	A CONSEQUE	ENCE OF):								
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9	Sequentisity list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUE	ENCE OF		0770		0				
¥	cause. Enter UNDERLYING			0								
ERTIFICATION	CAUSE (Disease or injury that initiated events	C DUE TO (OR AS	A CONSEQUE	ENCE OFI:								
EI	resulting in death) LAST			,							Ì	
岂』	College Brown	d										
7 1	PART II. Other significant condition	s contributing to death	but not res	ulting in the s	ındariyin	n causa d	lven in	Part i 24a WA	S AN AUTOP	ev 24	. WERE AUTOPSY FINDINGS	
5					, , , ,				RFORMED?		AVAILABLE PRIOR TO	
ā								1 🗆 YI	S 2 NO		OF DEATH?	
MEDICA											1 TYES 2 NO	
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH	YES X	NO [UNC	ERTAIN	<u> </u>				
HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE O	OF DEATH (Chec	k only one)							
잃	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/OL	stantiant 2 🗆	OTHE		/						
¥∥	27. MANNER OF DEATH	26a. DATE OF INJURY	1		_		idenca	6 Other (Specify				
효	1 Natural 5 Pending	(Month, Day, Year,	, , ,	186. TIME OF INJURY	28c. INJ WC	PRIC?	/	28d. OEŞÇRIBE H	OW INJURY	OCCURED		
À	2 Accident Investigation			M	1 🗆		NO					
	3 Suicide 6 Could not be	26a. PLACE OF INJU! building, atc. (Sp	RY — At home	, farm, atreet, fa	ctory, offic	Α.		28f. LOCATION (S	reet and Nur	mber or Rural	Route Number,	
"	4 Homicide datarmined							City or Town,	Jidio)			
	294. CERTIFIER	OLANI, T. H. L. L. L. L. L. L. L. L. L. L. L. L. L.		and the state of		/	2000					
COMPLET	(Check only	CIAN: To the best of my kno										
Ö	2 MEDICAL EXAMINE	R: On the beats of examinet	tion and/or inve	eatigation, in my	opinion, d	eath occurs	d at the	time, data and plac	a, and due t	to the cause(s) and manner as stated.	
2	256. SIGNATURE AND TITLE OF CERRETE	3				29c. LICE	NSE NUM	DER P	29d.	DATE SIGNED	(Month, Day, Year)	
m	1	>				2	121	500	•	7/	udat	
2	10. NAME AND ADDRESS OF PERSON, WH	Canada .				_//	111	0110		11	719)	

Cavanus (Type, Print) 32. REGISTRAR'S SIGNATURE DHMH-16 Rav 1/89



Amended 7-18.95

31. DATE FILED (Month, Dey, Year)

JUL 18 1995

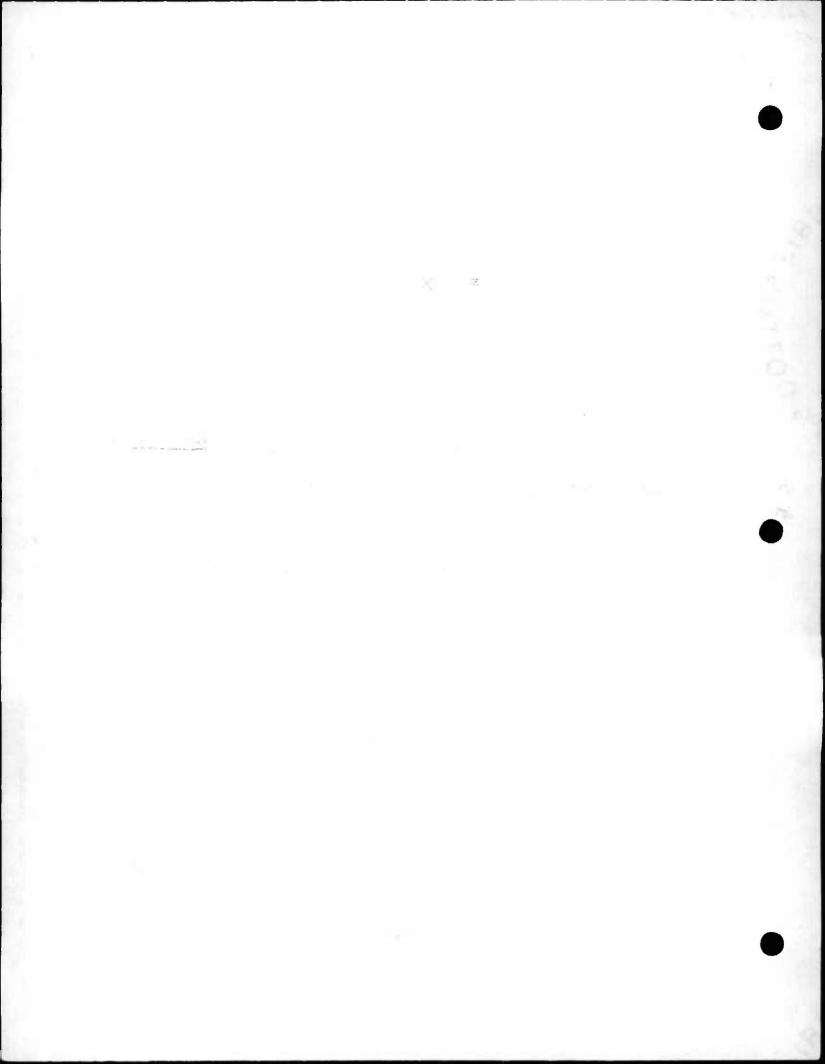
1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH N. JOSEPHINE HOWELL July 14 1995 0730 P 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Yea IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F Feb 26 1903 DAYS HOURS 488-07-1304 YRS. Tennessee Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Fairfield Nursing Center Crownsville Anne Arundel RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Anne Arudnel Crownsville 1 TYES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the bunial-transit 1454 Fairfield Loop Road United States retained by the hospital or attending physician 12. WAS DECEDENT EVER IN U.S. ARMED FORCEST YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, apecify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, Whita, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried ВУ 1 VES 2 NO Specify: 3 ₩ Widowed 4 □ Divorced White ETED. 15. OECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only his Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Practical Nurse Health Care 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First Middle Maiden Surname) Ħ unknown unknown notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Griffin G. Leslev 1801 Packer Court Bowie, MD 20716 must be executed within Z4 hours after death. Page 6 may 1 and completely filled in by the funeral director, pag) burial, cremation, or removal. 20a. METHOD OF DISPOSITION
1 Burlet 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c LOCATION - City or Town, State

RENTWOOD

Annapolis, Maryland DATE Lincoln Crematory 4 Donation 5 Other (Specify) 7/17/95 21. SIGNATURE DE FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home examiner 147 Duke of Gloucester St. Annapolis, MD medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, **Approximete** ahock, or heart feilure. List only one cause on each line. **IMMEDIATE CAUSE (Final** Onset and Death the disease or condition Preuminia 2 weaks resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760, OUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): traumatic · Chronic 10 48915 CERTIFICATION Sequentially list conditions, prior to If any, leeding to immediate signed by the attending physician Health and Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Diseese or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 6 PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? any Stain Synd/one 1 - YES 2 - 10 Shows 1 YES 2 NO been it, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN has be Dept. PHYSICIAN: WE 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The certificate h L DR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate before after death with the State HOSPITAL: OTHER:
4 Nursing Home 5 Realdence 6 Other (Specify) 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) this c 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 28c. INJURY AT WORK? marked. 1 Natural 1 YES 2 NO ВУ 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 8 Could not be 4 Homicide 28 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end placa, end due to the ceuse(a) and menner as stated. FUNERAL I within 72 h HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(a) and manner as stated. TO THE HOSPITY
TO THE FUNERA
DE filed within 7 296. SIGN FURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 116/95 121225 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 795 Aquahart Road, #203 Glen Burnie, Maryland 21061 STEPHEN M. ZEMEL M.D.

32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

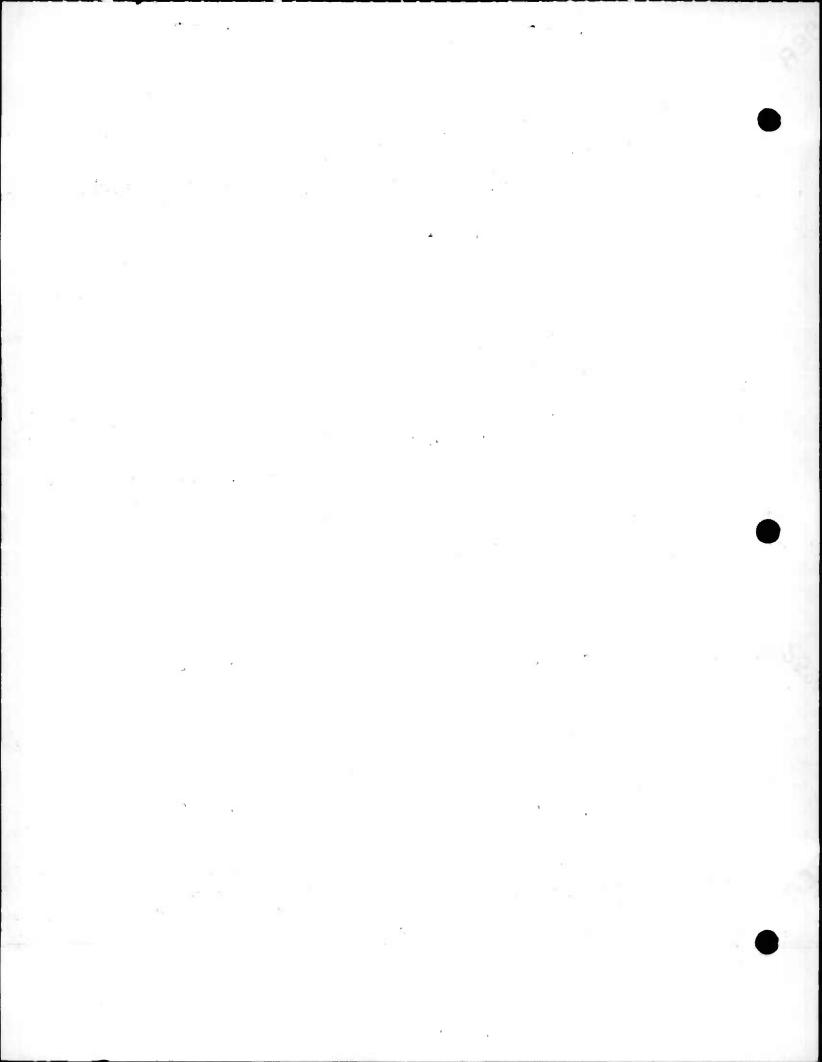


TO THE FUNERAL ORECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR

	REGISTRAR		CERT	IFICATE O	F DEATH		REG. NO	S. E.		- 1976		
	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATN		3.	TIME OF DEATH		
200	JUDITH	LEE HUTTO	N	-1-3-3-100		монтн		1995	YEAR 1	.0:05 A M		
	4. SOCIAL SECURITY NUMBER		8. AGE (In yrs. lest birth	"	R IF UNDER 24 HRS.	7 DATE O	E BIRTH	8	. BIRTHPLA	ACE (State or Foreign		
	142-24-9654	1 🗌 M 2 💢 F	63 YF	RS. MONTHS DAY	HOURS MIN.	March 12, 1932				ington, DO		
	9a. FACILITY NAME (If not institution, give :	treet and number)		9b. CITY, TOW	N OR LOCATION OF C	DEATN		9c. COUNT	Y OF DEAT	_		
5	NATIONAL NAVAL	BETHESDA		MONTGOMERY								
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CTTY TOWN OB LOCATION											
2				CITY, TOWN OR LO	CATION				100	d. INSIDE CITY LIMITS?		
9	Virginia Prin	ce Willia	m Ma	anassas					1[LIMITS?		
M		D 1		101. ZIP CODE				U.S.A		T COUNTRY?		
	11304 Smithfield		22111					ł.				
BY FUNERAL DIRECTOR	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced		EVER IN U.S. ARMED YES 2 NO IR OR DATES	If yes,	ECENDENT OF HISP/ specify Cuban, Mexic ES 2 🔯 NO Spec	cen, Puerto Ricen, atc.) Bis				American Indian, hite, atc. Cauc.		
		<u> </u>										
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)							SINESS/INDU	STRY			
اڌ	Elementary/Secondary (0-12) College (1-4 or 5 +) Home = Maker						Posi	dence				
Ž	17. FATHER'S NAME (First, Middle, Last)		110	Jine-Maker								
	Albert H. Hollan	d			18. MOTHER'S N	AME (First, M	iddle, Maiden	Surname)				
ᆱ	19a. INFORMANT'S NAME (Type/Print)			1.000								
2	Jeffrey L. Hutto	n			et and Number or Rural							
ł	20a. METHOD OF DISPOSITION						<u> </u>					
	1 Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	complete commeter	ATE OF DISPOSITION or other place)				CATION — CH				
	4 Donation 5 Other (Specify) Arlington National Cemetery 7/17 Arlington, Va. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE											
	> Hory Maju	rell		BLAS	IUS-BAKEF		AL HOME anassas, Va. 22110					
- 1	23. PART i. Enter the diseases, or	complications that	caused the death.									
	23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final											
	disease or condition resulting in death)		ARRHYTHM									
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F	th any, leading to immediate cursons. Due to (OR AS A CONSEQUENCE OF):											
E I	CAUSE (Disease or injury 5 c.											
Ē	that initiated avanta DUE TO (OR AS A CONSEQUENCE OF): resulting in daath) LAST											
		d										
EDICAL CERTIFICATION	PART ii. Other significant condition	a contributing to d	laath but not reault	ing in the underly	ing cause givan ir	Part I.	24a. WAS AN PERFOR			RE AUTOPSY FINDINGS		
8							1 XYES 2		COI	MPLETION OF CAUSE		
ME						OF DEATH? 1 □ YES 2 ☑ NO						
	DID TOBACCO USE CONT	RIBUTE TO CAL	JSE OF DEATH	YES 🗆 NO	☐ UNCERTAI	N 🗆				A		
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSDITAL	26. PLACE OF	DEATN (Check only or	ne)							
Š	1 TES 2 NO	HOSPITAL;	ER/Outpatient 3 🗆 DO	OTHER: A 4 Nursing N	ome 5 🗆 Residence	6 Other	(Specify)					
PHYSICIAN:	27. MANNER OF DEATH	28a. OATE OF II (Month, Day			NJURY AT WORK?	28d. DESC	PIBE NOW I	NJURY OCCU	RED			
B	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO							
ED	3 Suicide 8 Could not be	28e. PLACE OF building, a	INJURY — At home, te tc. (Specify)	rm, street, tectory, o	fice		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
	4 Homicide determined	4				0.1, 0	i lown, orallo,					
COMPLET	29e. CERTIFIER 1 X CERTIFYING PNYS	CIAN: To the beat of n	ny knowledge, death oc	curred at the time, d	ate and place, and du	e to the caus	e(a) and mar	mer sa stated				
<u> </u>	one) 2 MEDICAL EXAMINE									d manner ea stated.		
	306. SIGNATURE AND YTTLE OF CERTIFIE				29c. LICENSE NU					onth, Day, Year)		
₩	M.Z.LL	ovsers	\sim		01 01 05 0		774)	▶ A	4LU	11. 1995		
유	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAME	DEATH (ITEM 27)	(Type, Print)				TON	O I I I			
-	M.ZUHDI JASSER.				NATIONAL				JENTE	K		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR			BETHESDA	A MD Z	.0089-	3600				
Į.	1111 0 G 100E	deli Abus	Jean Rand II									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

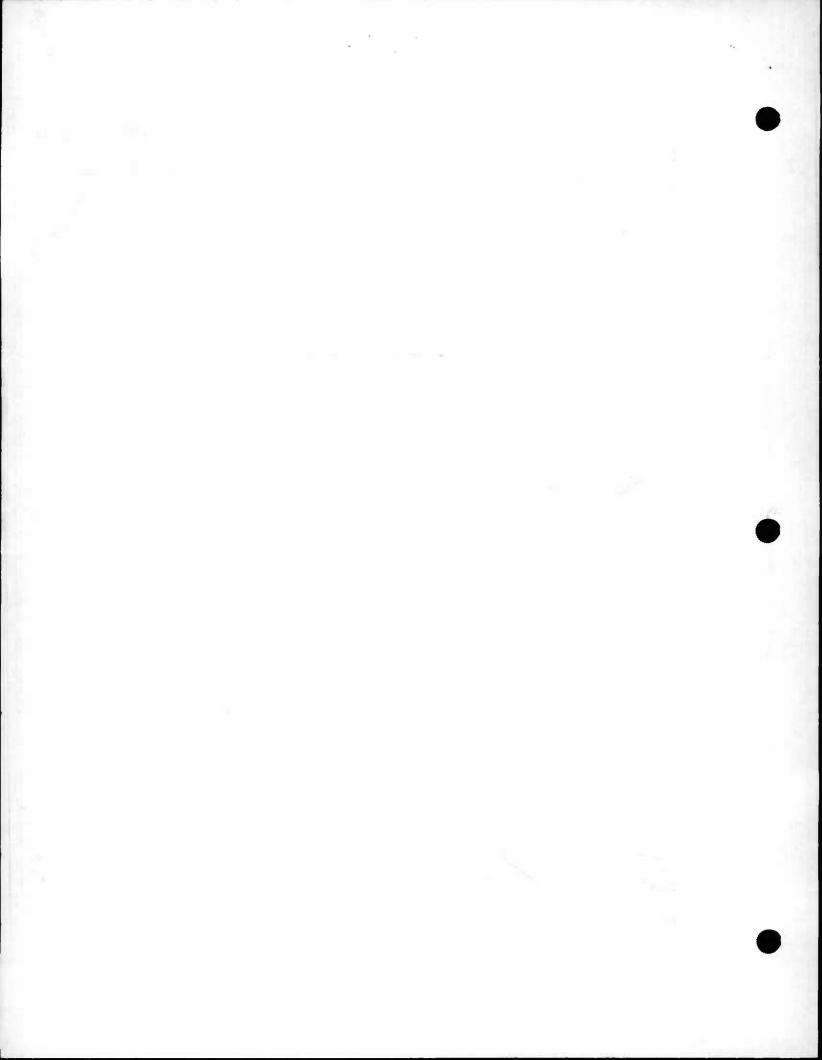
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR 1 - STATE REGISTRAD

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO				
	1. DECEOENT'S NAME (First, Middle, Last) Marjorie	Ann			HILLMAN	2. DATE OF DEATH MONTH D	\$ 19	3. TIME OF DE	-	
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. lest birthday)							
	219-36-6220	1 M 2 F	56 YRS.	MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) 5/30/1939		6. BIRTHPLACE (State or Country) [arvland]	Foreign	
	9a. FACILITY NAME (If not institution, give s	treet and number)		9b. CITY, TOWN	OR LOCATION OF DI			TY OF OEATH		
DIRECTOR	PENINSULA REGIONA	L MEDICAL	CENTER	SALI	SBURY		W	WICOMICO		
	10a. STATE 10b. COUNTY	Y	10c. CIT	TY, TOWN OR LOC	TION			10d. INSIDE C	TV	
1 %	Maryland Worce	etor						LIMITS?		
	10e. STREET AND NUMBER	ster	F	ocomoke				1 YES 2]		
A A		** **		,	of, ZIP CODE		10g. CITIZI	EN OF WHAT COUNTRY	?	
9	2141 Worcester H				21851		U	SA		
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EV FORCES? 1	ER IN U.S. ARMED	13. WAS DE	CENDENT OF HISPAN	IC ORIGIN? (Specify Yas n, Puerto Rican, etc.)	or No-	4. RACE — American in Black, White, etc.	dian,	
B⊀	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE WAR			S 2 NO Specify			Specify:		
								White	€	
TED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	(Give kind of	WORK done during in		16b. KIND OF BUS	SINESS/INOU	STRY		
"	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT u	se retired.)						
COMPLET	11		<u>Beamstre</u>	ss & Hor	nemaker	Pocomoke	Garm	ent Factor	v	
8	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Malden		2000		
BE	Richard Wallace				Mary E	lizabeth M	essic	k		
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	AOORESS (Street	end Number or Rural I	Route Number, City or Tow	n, State, Zip C	Code)		
유	Robert M. Hillman	Jr.	2007 N	ewbridge	Rd Po	comoke, Md	21	Ω51		
	20a METHOD OF DISPOSITION		20h PLACE AND DATE	OF DISPOSITION /	leme of	04TE 200 LO	CATION C	tu as Town State		
	1 Burial 2 Cremation 3 Rame 4 Donation 5 Other (Specify)	oval from Stata	First Ban	tist Con	eterv	7/12 Poc	omoleo	C24 M2		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	- IIDC Dap	22. NAME /	NO ADDRESS OF FA	CILITY	Olloke	CILY, Md.		
	- C -45 A	11 0		Mels	on Funer	al Home				
	Dury 5. 11	Melson		PO Bo	x 64, Po	comoke Cit	y. Md	21851		
	23. PART i. Enter tha diseasea, or o	complications that car	used the deeth. Do	not anter tha m	ode of dying, suc	h es cardiac or reapi	ratory erre	et, Approxi	mete	
	ahock, or heart fellure.	List only one cause of	on eech line.						Betwaen nd Daath	
		11. 54	ica Laca	611	/	/		i		
	reaulting in death)	DUE TO (OR	AS A CONSEQUENCE O	F):	my mp	homa		2 70	fair-s	
-				•				į		
CERTIFICATION	Sequentially liet conditione, if eny, leeding to immediate	DUE TO (OR	AS A CONSEQUENCE O	F):						
\	cause. Enter UNDERLYING									
	CAUSE (Disease or Injury that initiated events	OUE TO (OR	AS A CONSEQUENCE O	F):						
눈	resulting in death) LAST									
빙										
A	PART ii. Other aignificent condition	e contributing to dee	th but not resulting	in the underlying	g ceuee given in	Part i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY AVAILABLE PRIO		
EDICAL	Seps:s					1 _ YES 2	1 0	COMPLETION OF		
						_ 10.00 7	2	OF DEATH?	Cun	
2	DID TOBACCO USE CONTE	RIBUTE TO CAUSI	E OF DEATH Y	S I NO I	UNCERTAIN	<u>-</u>		1 123 2)	(
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA			,				
1 28	EXAMINER?	HOSPITAL:	Outpetlant 2 004	OTHER:	3					
. ≩	27. MANNER OF DEATH	26a. DATE OF INJU			DURY AT	28d. DESCRIBE HOW II	HIPW COOK	1050		
	1 Natural 5 Pending	(Month, Day, Ye		JURY W	YES 2 NO	200. DESCRIBE NOW II	NJUHY OCCU	HED	- 1	
B	2 Accident Investigation	200 BLACE OF IN	HADY AA barra da							
8	3 Suicide 6 Could not be 4 Homicide detarmined	building, etc. (IURY — At home, ferm, (Specify)	street, factory, offi		28f. LOCATION (Street a City or Town, State)	and Number of	Rural Route Number,	- 1	
COMPLETED										
PL	29a. CERTIFIER (Check only									
O	one) 2 MEOICAL EXAMINE	R: On the basis of examin	nation and/or investigation	on, in my opinion,	death occured at the	time, date and place, an	d dua to the	cause(a) and manner as	stated.	
E C	296. SIGNATURE AND TITLE OF CERTIFIER	2			29c. LICENSE NUN	IBER	29d, DATE	SIGNED (Month, Day, Yee	()	
0	J- E.	/ac	. m.o.		0300					
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF	/	Print)			-	5019 1	15	
	James E.	Martin	N.D.	145	E. G	11 5t	5-11	50- n	10	
10			/	_		/)	1.	-	
1	31. DATE FILEO (Month, Day, Year)	32/REGISTRAR'S	SIGNATURE							
7	JUL 14 1995	32/REGISTRAR'S	SIGNATURE							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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31. DATE FILED (Month, Day, Year)

JUI

32. REGISTRAR'S SIGNATURE

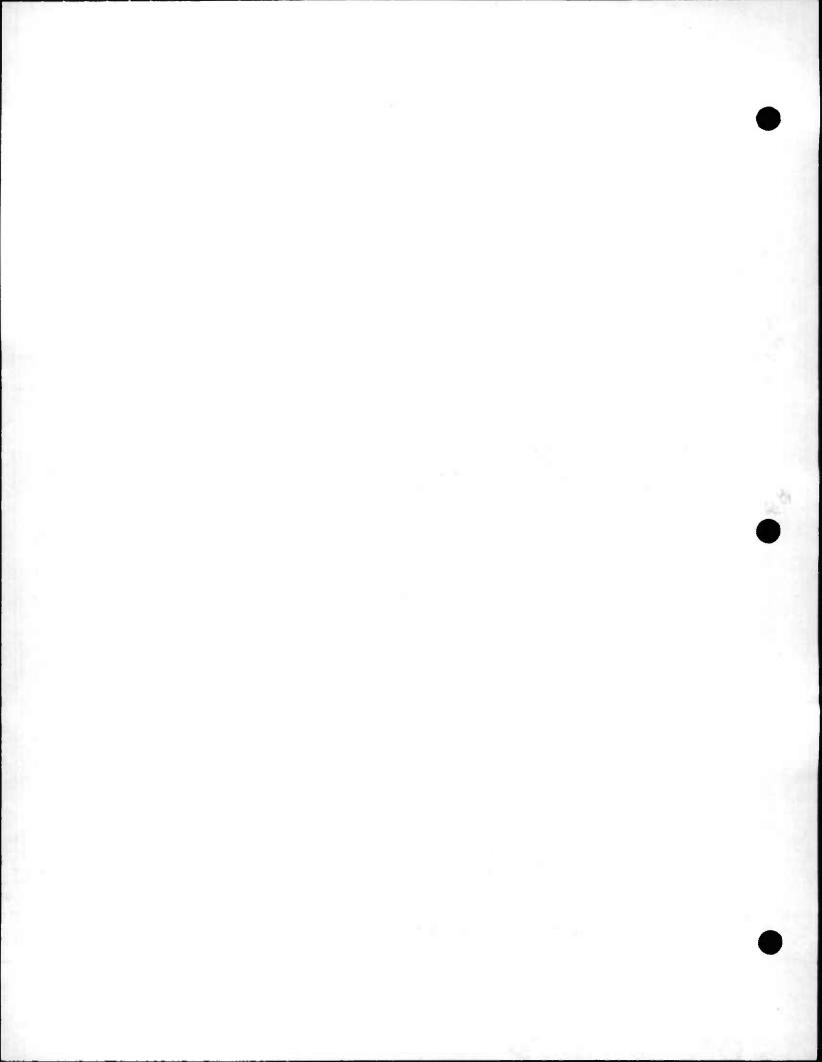
30. NAME AND ADDRESS OF PERSON WHD COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1995

4

										9	5	23200		
	1 - FOR STATE REGISTRAR	STATE OF W	IARYLAND /	DEPAR	TMEN	T OF H	EALTH DEAT	AND I	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Las	10			IOAI	_ 0.	DEA	-	2. DATE OF DEATN					
	William Harry	Hutchins,	Jr.							* 1995	YEAR	3. TIME OF DEATH 3:11 p		
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. las	t birthday)		R 1 YEAR	IF UNDER		7. DATE OF BIRTH		6. BIRTH	NPLACE (State or Foreign		
	217 16 3680	1 🔀 M 2 🗆 F	89	YRS.	MONTHS	DAYS	HOURE	MIN.	July 15	1905	MD Country)			
-	9e. FACILITY NAME (If not Institution, giv						R LOCATE	ON DF DE	Total Control of Separation					
Ö.	8331 Mt. Harmo	ny Lane			Ow:	ings	gs Calvert							
EC	10a. STATE 10b. COU	ITY		10c, CIT	Y. TOWN	OR LOCAT	ION			10d. INSIDE CITY				
DIRECTOR	MD Cal	vert			ving							LIMITS?		
	10e. STREET AND NUMBER		101. ZIP CDDE							IZEN OF V	WHAT COUNTRY?			
ER	8331 Mt. Har					20736	5		1	JSA				
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AR	MED	13. WAS DECENDENT OF HISPA			F HISPAN	IIC ORIGIN? (Specify Yes		14. RACE	E — American Indian,		
BY F	1 Never Married 2 Narried 3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES	10			2 X NO		n, Puerto Rican, etc.)		Speci	k, White, etc.		
			16e. DECEDENT'S USUAL OCCUPATION								white			
H	15. DECEDENT'S EI (Specify only highest gra	de completed)	(Gi	ve kind of a Do NOT us	work done	during mos	ON st of workin	g	16b, KIND OF BU	SINESS/IN	DUSTRY			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	era1	-		r		Fune	eral	Serv	ice		
8	17. FATNER'S NAME (First, Middle, Last)					18. MOTE	IER'S NA	ME (First, Middle, Maiden						
BEC	William Harry	s, Sr.				Ain		Estelle F		sty				
	19e, INFORMANT'S NAME (Type/Print)		198	. MAILING	AODRES	S (Street e	nd Number	or Rural F	Route Number, City or Tow	rn, State, Zij	p Code)			
임	Margaret H. Phi	.pps	74	145 B	risc	oe's	Tur	n Rd	., Owings,	MD	207	36		
	20e. METHOD OF DISPOSITION 1 Duriel 2 Cremation 3 Re	moval from State	20b. PLACE A cemetery, crei				me of		OATE 20c. LO	CATION -	City or To	wn, State		
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVINE.	4	Mt. F	larmo	ny U	M Ch			7-12-95	Owi	ngs,	MD		
1 1	21. SIGNATURE OF PURGETAL SERVING	egensee,	10	2			D ADDRES							
Ш	111.11/19	Krel	Mys	elo							_	s, MD 20736		
1	23-PART I. Enter the diseases, D	r complications that	coused the de	eth. Do r	not enter	the mod	de of dyi	ng, suci	h ss cerdiec or resp	iratory er	rest,	Approximete		
	immediate Cause (Final Onset and Death													
	disease or condition resulting in death)	Phei								Days				
		OUE TO (OR AS A CONSED	VENCE OF	F):	. 1	1	- 1	21.					
o N	Sequentisity list conditions,	b. ATTER	105C161	-04-15		CVTU	1000	541	an pised	UP		yeurs		
RTIFICATION	if eny, lesding to immediate cause. Enter UNDERLYING	Advan	sepal -	OENCE O	chan	mb	M	MAR	andbinat	4.		LARM		
트	CAUSE (Disease or Injury that initiated events	C. DUE TO (DR AS A CONSEC	Description Cardiovasuli Description of: Is chemic Myoca Descouence of:					WI WID PAY	7		Gent		
ᇤ	resulting in death) LAST	d.												
CEI	PART II Other significant conditi	one contributing to	doubt had not a		- 41									
g	PART II. Other significant conditi	A	neur			nderiying	ceuse g	iven in	Part i. 24a. WAS AN PERFDE		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO		
MEDICA	Contension A	ctora Hh	1345	15	21	0	L.		1 TYES 2	NO		OF DEATH?		
	DID TORACCO LISE COM	TRIBLITE TO CAL	ICE OF DEAT	/ ±	>0\U	U ADI			Dispuse			1 TES 2 ND		
AN	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL	T CAL		E DE DEAT		NO 🔼	UNC	ERTAIN	4 L]					
PHYSICIAN:	EXAMINER?	HOSPITAL:			OTHE	R:								
Η̈́	27. MANNER OF DEATN	28a, DATE OF I		26b. TIM		28c. INJL		sidence	6 Other (Specify) 28d. OESCRIBE NOW I	N HIRY OC	CUBEO			
	1 Natural 5 Pending Investigation	(Month, Day	y, Y6ar)	INJ	URY M	WOI		ND	Tour ordering House		CONLO			
Э ВУ	2 Accident Investigation 3 Suicide 6 Could not b	26e. PLACE OF	INJURY — At hor	ne, farm, s	treet, fec				281. LOCATION (Street of	and Number	or Rural A	loute Number,		
TED	4 Nomicide determined	Nc. (Specify)						281. LOCATIDN (Street and Number or Rural Route Number, City or Yown, State)						
1 1	29a. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the best of r	ny knowledge, des	ith occurre	d at the t	Ime, date	end place	and due	to the ceuse(e) end mar	nor es el-	led			
COMPLET									time, date end place, en) end menner es stated.		
ЕСС	29b. SIGNATURE AND TITLE OF CERTIF											The second second		
00	Gerald	ald P. Sterner My					DIDE				29d. DATE SIGNED (Month, Dey, Year)			
2		HD COMPLETED CALLS			_				•			1 - 11173		

DHMH-18 Rev 1/89



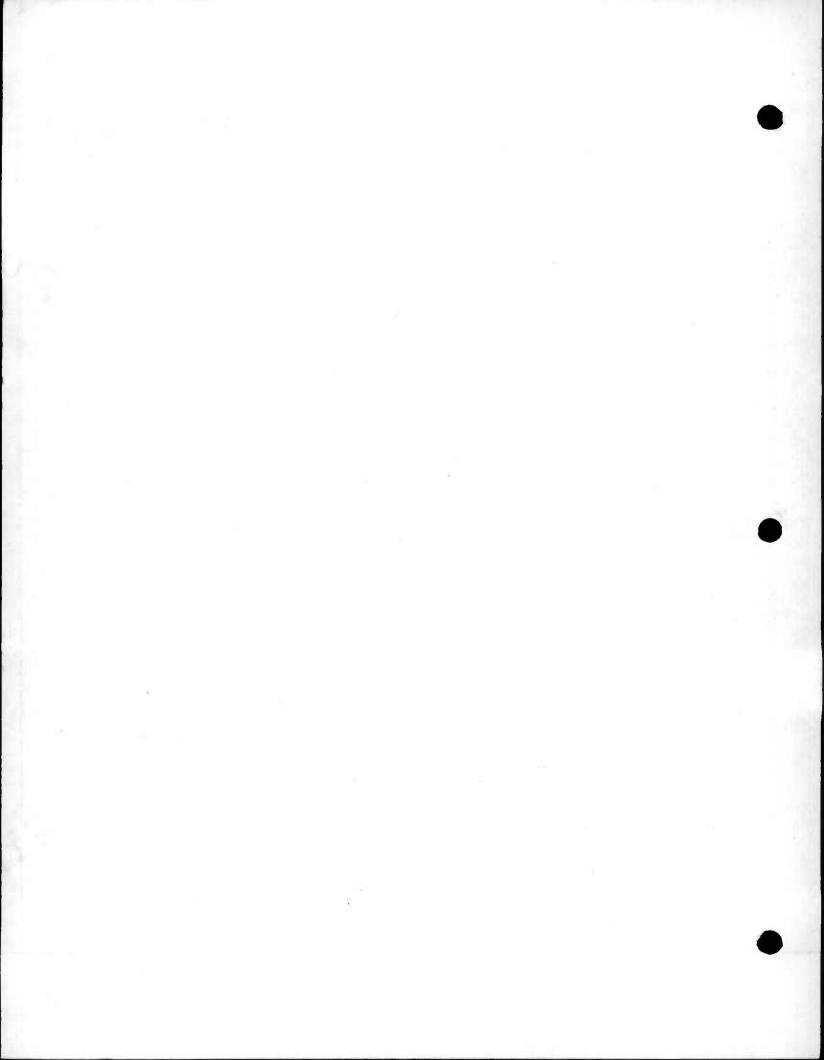
1 -

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

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--

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEOENT'S NAME (First	, Middle, Last)								2. DATE OF MONTH	OEATH DA	v	YEAR	3. TIME OF DEAT	Н	
	Kathleen			Hart						July 17, 1995 6					A M	
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. lest		IF UNDER 1	YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF (Month, De	BIRTH W. Weer)		8. BIRTH Count	IPLACE (State or Fo	reign	
	219-12-229		1 M 2 X F	71	YRS.	MONTHS	UATS	HOURS	MIN.		8, 19	924		ryland		
	9a. FACILITY NAME (If not in					9b. CITY,	TOWN C	R LOCATIO	ON OF DE	EATH		9c. COU	NTY OF D	EATH		
5	Frederi	ck Memo	rial Ho	spital			Fre	ederi	ck			Fre	deri	ick		
EC.	10a. STATE	10b. COUNTY		-	10c. CITY,	TOWN OF	LOCAT	ION					10d. INSIDE CITY			
DIRECTOR	Maryland		Frederic	ck	Frederick									LIMITS?		
	10e. STREET AND NUMBER							ZIP CODE				WHAT COUNTRY?				
ER	1608 Ro	ck Cree	ed Dr./	Apt. 5				217	02			States				
FUNERAL	11. MARITAL STATUS	13. W	AS DEC	ENDENT O	F HISPAI	NIC ORIGIN? (S	pecify Yes	_		E — American India k, Whita, atc.	ın,					
BY F	1 Never Married 2 X 3 Widowed 4 Divo		o	1	YES	2 NO	n, Mexica Specifi	in, Puerto Rica y:	n, etc.)		Speci	ity:				
		EDENT'S EDUCAT	TION	L.o. no.		1								White	9	
COMPLETED	(Specify only	ring mo	N st of workin	g	16b. KJ	ID OF BUS	INESS/IN	DUSTRY								
7	Elementary/Secondary (0-12) College (1-4 or 5+) iide. Do NOT use retired.) 12 Secretary									Rug	iness	,			1	
OM	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER															
BE C	Ralp						Stone									
	19a. INFORMANT'S NAME (7			ADDRESS	Nettie Ellen Smith Stone RESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
2	Harold J. H	lart									,Md.2170)2				
	20a. METHOD OF DISPOSITI		F DISPOSIT	ION (Na	me of		_									
	4 Donetion 5 Other	(Specify)	er clace) Ceme				OATE 20c. LOCATION — City or Town, State 7-20 Hagerstown, Maryland					1				
	21. SIGNATURE OF FUNERA	L SERVICE LICEN	ISEE	\		22. N	22. NAME AND ADDRESS OF FACILITY Stau						ffer Funeral Home			
	Lam	poss	ossumtown Pike/Frederick,Md.21702						2							
	23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	Interval Cause Cause (Final													tween		
	disease or condition													/-		
	resulting in death) a. Cloud Mysterdia Angureta mutte Due TO (OR AS A CONSEQUENCE OF):													u.		
Z																
CERTIFICATION	Sequentially list conditions, It any, leading to immediate b. OUE TO (OR AS A CONSEQUENCE OF):															
5	cause. Enter UNDERLYi CAUSE (Disease or Inju		DUE TO #	OR AS A CONSEC	HENCE OF											
Ē	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST															
E	d															
	PART ii. Other significa	nt conditions	contributing to d	laath but not re	suiting In	the und	erlying	cause g	iven In	Part I. 24s	. WAS AN		24b.	WERE AUTOPSY FIN		
MEDICAL	types	Class	co							10	YES 2			COMPLETION OF C		
ME														1 TYES 2 OFN	。	
ž	DID TOBACCO U	SE CONTRIE	BUTE TO CAL	JSE OF DEAT	H YES	□ N	0 🔯	UNC	ERTAIN	v 🗆			_	P	- 1	
PHYSICIAN	25. WAS CASE REFERRED TO EXAMINER?		IOSPITAL:	28. PLACE	OF DEATH	(Check or										
YSI	1 TYES 2 THO	1	☐ Inpetlant 212	ER/Outpetient 3				5 🗆 Ra	aldenca	6 Other (Sp	ecity)					
H	27. MANNER OF DEATH 1 Natural 5	Pending	28a. DATE OF II (Month, Day		28b. TIME INJU	OF 2 RY	8c. INJU	JRY AT RK?		28d. OEŞCRI	BE HOW IN	JURY OC	CUREO			
ВУ	2 Accident	investigation				М		ES 2	NO							
8		Could not be determined	26a. PLACE OF building, e	INJURY — At honic. (Specify)	ne, tarm, str	eet, factor	y, office			28f. LOCATIO City or To	N (Street al wn, State)	nd Number	or Rural R	loute Number,	- 1	
COMPLETE	29a. CERTIFIER															
MPI	(Check only		N: To the best of n													
0	2 MEOI	CAL EXAMINER:	On the basis of axa	mination and/or in	weatigation,	In my opi	nlon, de	ath occur	ed at the	time, data and	placa, and	dua to th	a cause(s) and manner se at	rted.	
C) II	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)															
	290. SIGNATURE AND TITLE	OF CENTIFIER		7 /	Brancis E. Seulers MD D30496 Md. >7/18/55 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 200 W. 9+4 St. Frederick, Md 21761											
8	Frank	is E	. /	Zent	20	10/1		130	349	6 M	1.	1	1/18	155		
	30. NAME AND ADDRESS OF	PERSON WHO C	COMPLETED CAUSE	OF DEATH (ITEM	27) (Type, F	Print)		130	149	10 M	7/.	> 7	1/18	155	\dashv	
8	Frank	is E	6 ST.	S AUGNATURE	27) (Type, F	m)) erini)	ck	130	M.	121.	76	> 7	7//3	9/55		



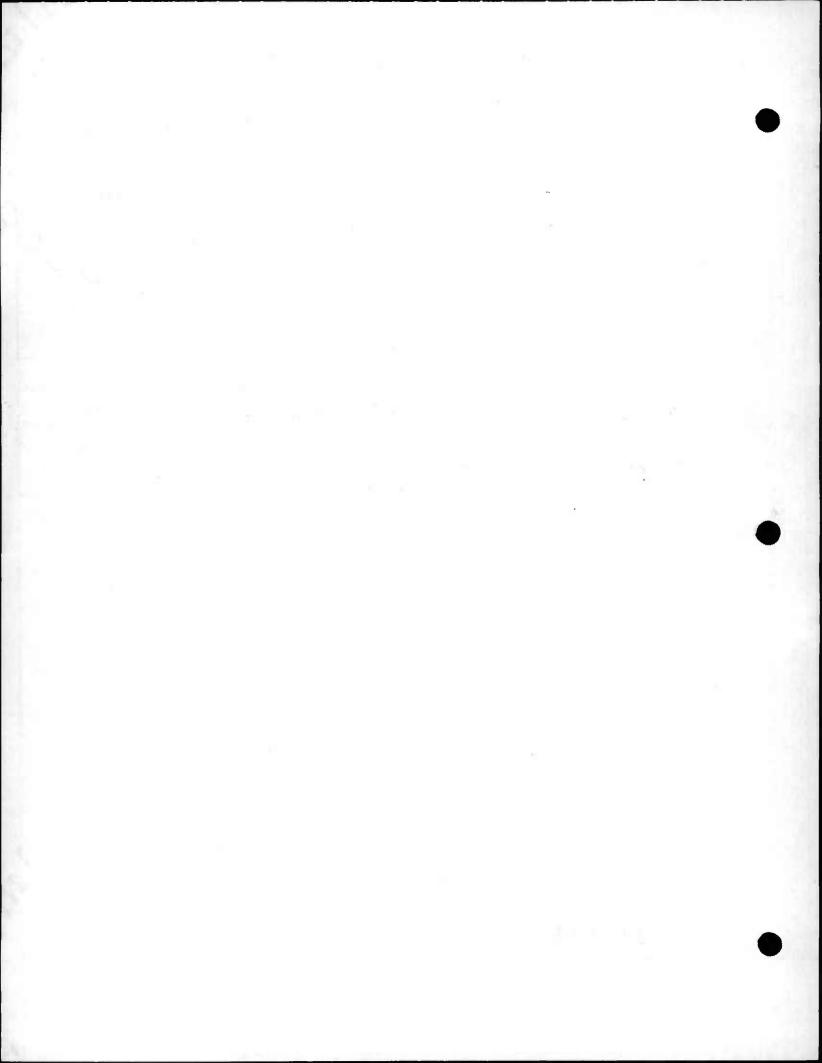
1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)

2. DATE OF DEATH AND MENTAL HYGIENE REG. NO.

	- 1		1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH MONTH D	AY	YEAR	3. TIME OF DEATH			
			Rose			H	AJDU	CEI	K	July 14		95	3:30pm M			
_			4. SOCIAL SECURITY NUMBER 060-32-3991	5. SEX 6.	AGE (In yrs. last	birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb 12,19:		BIRTHP	LACE (State or Foreign			
3 should			9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY	TOWN	OR LOCATION OF DE		9c. COUNT					
2.3		СТОВ	Meridian Nursin				I	rec	<u>lerick</u>	1	Fr	eder	ick			
Pages		DIRE	MONTE 10b. COUNT				Y, TOWN C						IOd. INSIDE CITY LIMITS?			
Ę		- 1	Maryland Fre	ederick			Fred	_	Of. ZIP CODE				I ☐ YES 2XQXNO			
020 physician. burial-transit permit, Pages 1, 2.		FUNERAL	5820 Genesis Lar						2170)1	17 0	J.S.A	A.			
# 5 O		B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 IF YES, OIVE WAR (YES 2 X N	WED O	- 1	f yes, a	CENDENT OF HISPAN pecify Cuban, Maxica S 2 NO Specify		or No- 1	- 14. RACE — American Indian, Black, White, etc. Specify: White				
21215 al or attend for use as			15. DECEDENT'S EDU (Specify only highest gradi		16a, DEC	CEDENT'S	USUAL OC	CUPAT	ION nost of working	16b. KIND OF BU	SINESS/INDU	STRY				
AND 21 he hospital or detached for u		COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)		DO NOT US OMEM					Own H	lome				
7 5 8	f at once.	шИ	17. FATHER'S NAME (First, Middle, Last) Nickolas		-	SINE			18. MOTHER'S NA	ME (First, Middle, Melden		PAVE	ΣΥ			
AAR etained should	notified	TO B	190. INFORMANT'S NAME (Type/Print)							Route Number, City or Tow						
By be re	e e	- 1	Mrs. Amy J. Rule			5400 White Mane, Columbia, Maryland 21045										
6 m Stor,	must		1 Burlai 2 M Cremetion 3 Ren 4 Donation 5 Dimer (Specify)	noval from State	cemetery, cren	nd DATE (natory or of Shiir	her place)	ma ma	tory Jul	15,1995 Sr	cation — ci nithah	ty or Tow	Marcal and			
TIN Page ral dir	examiner		21. SIGNATURE OF BUNEFIAL SERVICE LI	CENSEE	0	DOGE	22.1	NAME A	AND ADORESS OF FA	CILITY						
BALTIMOF after death. Page 6 m by the funeral director,	-		Keeney & Basford P.A. Funeral Home 106 E Church St. Frederick, MD 21701 3. PART Enter the diseased or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate													
aff	or remove		23. PART L Enter the diseases, or shock, or heer! failure.	complications that ca	used the dec	th. Do n	ot enter	the m	ode of dying, suci	es cerdiec or respi	ratory erres	st,	Approximete			
D & B			IMMEDIATE CAUSE (Final	a. Hyperti									interval Batwean Onset and Death			
SO within	ent,		resulting in death)			months										
68760 executed with and comple		No.	Sequentielly list conditions,	b. Hyperte, Due to (OR	nsion								yeans			
Cian be	prior to buris	ÄŢ	if sny, lesding to immediate cause. Enter UNDERLYING	// DUE TO (OR	AS A CONSEC	UENCE OF	7):				Q					
	Hygiene p	CERTIFICATION	CAUSE (Diseese or injury that initiated events	COUE TO (OR	AS A CONSEO	UENCE OF	7):									
P.O leath certi	E 5		resulting in desth) LAST	d												
() o	injury,	- 11	PART ii. Other significent condition										/ERE AUTOPSY FINDINGS			
ECORD quires that the n signed by th	any any	MEDICAL	Digital Ischen, Mittal regus DID TOBACCO USE CONT	a, COPO, I	Cheum	ato.	dA	rth	ritis	PERFOR		C	MAILABLE PRIOR TO DMPLETION DF CAUSE IF DEATH?			
mm (ii) (ii)		ME	mitral regus	gitation.									TES 2 NO			
	23 s	Ä	DID TOBACCO USE CONT	RIBUTE TO CAUS	E OF DEAT	H YE	S 🗆 1	10 [UNCERTAIN	1 🗆			~			
F VITAL R SICIAN: The law n certificate has bee	State Dept.	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 Nio	HOSPITAL:		OF OEAT	OTHER	:								
OF V PHYSICIA This certif	d the	PHYS	27. MANNER OF GEATH	28s. OATE OF INJU	JRY	28b. TIMI	E OF	28c. IN	me 5 Realdenca	6 Other (Specify) 28d. OESCRIBE HOW I	NJURY OCCU	RED				
N O N O D O D O D O D O D O D O D O D O	7	8	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Ye	sar)	INJ	M		ORK? YES 2 NO							
DIVISION OF VITAL OR ATTENDING PHYSICIAN: The law OIRECTOR: After this certificate has t	after d	ETED I	3 Suicide 8 Could not be determined	26a. PLACE OF IN. building, etc.	JURY — At hon (Specify)	ne, ferm, a	treel, facto	ery, offic	ca	281. LOCATION (Street a City or Town, State)	and Number or	Rural Rou	ite Number,			
DIV	Hours		29a. CERTIFIER (Check only	ICIAN: To the best of my i	cnowledge, dea	th occurre	d at the ti	ne, det	e end place, end due	to the ceuse(a) and mar	ner as stated					
THE HOSPITAL THE FUNERAL	be filed within 72 i	COMPL		R: On the besis of examin									and manner es stated.			
보 교 보 보	ORTA	ш	29b. SIGNATURE AND TITLE OF CERTIFIE	1					29c. LICENSE NUM	BER	29d. DATE S	SIGNED (A	fonth, Day, Year)			
55	IN P	8	Mary P. F	Lowell	~ ~				D46	075	Ju	ly 1	4. 1995			
			30. NAME AND ADDRESS OF PERSON WI								-					
			Dr. Mary P. Howe 31. DATE FILED (Month, Day, Year)	32. BEGISTRAR'S	915 TO	LLho	use	Ave	nue. Fred	lerick. Mai	cyland	217	01			
			JUL 1 9 1995	32. REGISTRAR'S	whom Ra	dall							i			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing a hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

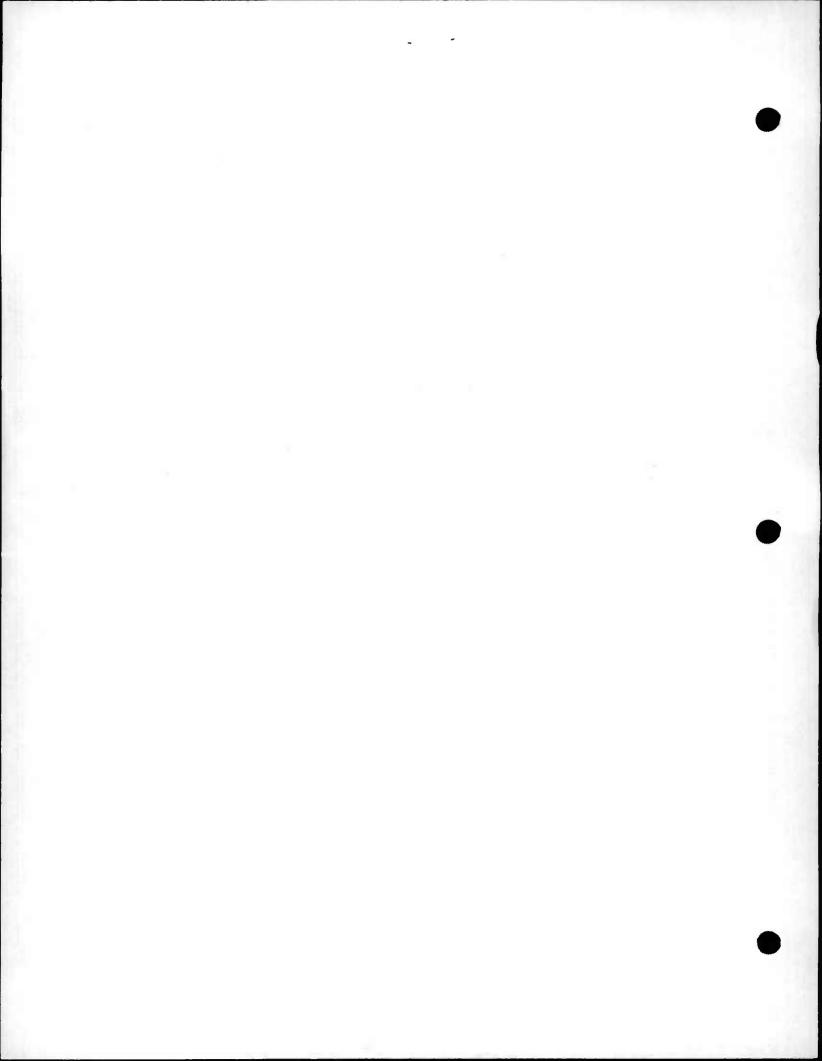
DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

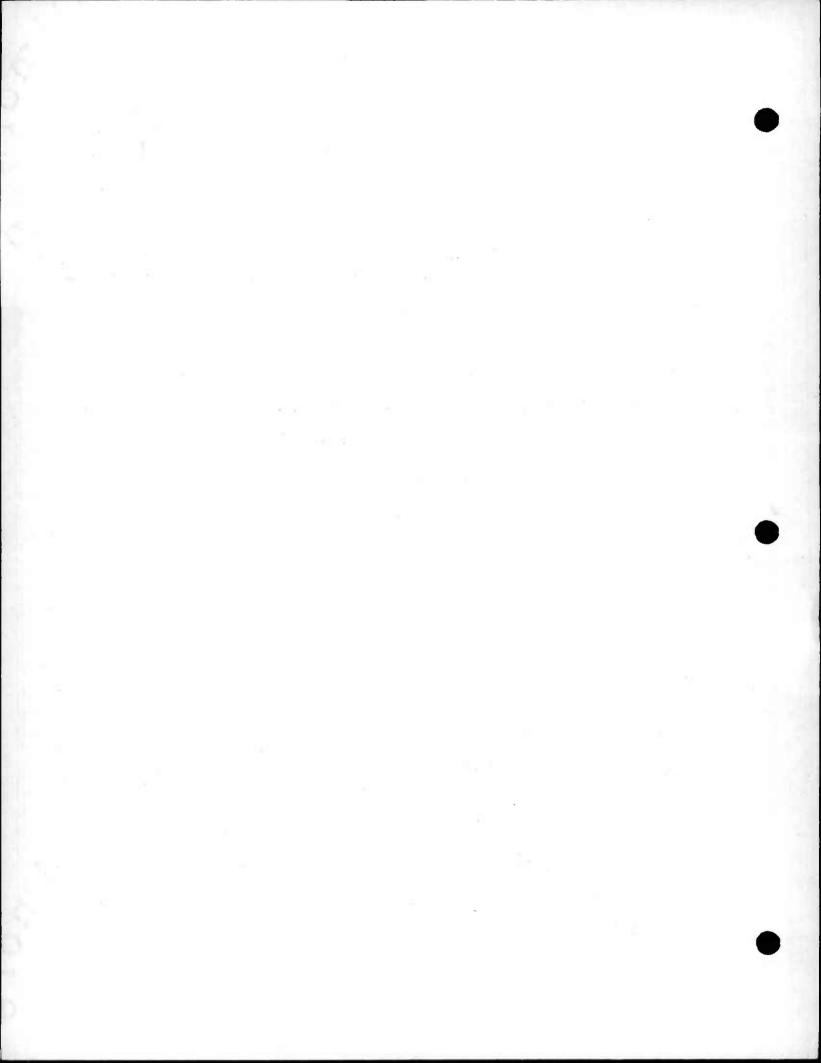
BALTIMORE, MARYLAND 21215-0020

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	SIAIE OF N	MARYLAND / [CEI	JEPAF RTIF	ICATE	OF H	DEAT	AND I		HYGIEN REG. NO.			
	1. DECEDENT'S NAME (First, Middle	e, Last)							2. DATE OF	DEATH		12.2	3. TIME OF DEATH
	Charles	Jame	S		Ног	ward			Jul	v 16		995	1:42 A: M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. last t	oirthday)	IF UNDER		IF UNDER		7. DATE OF (Month, L	BIRTH		8. BIRTH	HPLACE (State or Foreign
	226-26-2278	1 M 2 □ F	70	YRS.	MONTHS	DAYS	HOURS	MIN.	OCT.		1924		TH CAROLINA
_	9a. FACILITY NAME (If not institution						R LOCATIO	ON OF DE			9c. COL	JNTY OF D	DEATH
5	Physicians Mem	orial Hospi	tal		La	aPla	ta					Char	les
E C		COUNTY		10c. CIT	Y, TOWN O	R LOCAT	ION				10d. INSIDE CITY		
뚬	MARYLAND	CHARLES		RRY	ZANG	DOAT)				LIMITS?		
A F	10e. STREET AND NUMBER			BRYANS ROAD							WNAT COUNTRY?		
띮	#2787 MARSHALL	HALL ROAD				_ _	206	16					STATES
FUNERAL DIRECTOR	11. MARITAL STATUS		T EVER IN U.S. ARME		13. V	WAS DEC	ENDENT O	F HISPAN	HC ORIGIN? (Specify Yes		14. RACE	E American Indian.
BY	1 Never Married 2 Marrie 3 Wildowed 4 Divorced	AR OR DATES				ZXX NO		n, Puarto Ric	an, etc.)		Speci		
	15. DECEOENT	146										BLACK	
	(Specify only higher	(Give	kind of	USUAL OC work done d se retired.)	CUPATIO	on st of workin	g	18b. K	IND OF BUS	BINESS/IN	DUSTRY		
2	Elementary/Secondary (0-12) 9TH GRADE	MBEF						OVERN	TMENT	r			
COMPLETED	17. FATHER'S NAME (First, Middle, L	ast)	1201	. IDDI			18. MOTH	IFR'S NAI	ME (First, Mid			L	
	UNKNOWN								AE HO) S	
) BE	19a, INFORMANT'S NAME (Type/Pris	n)	19b. I	MAILING	ADDRESS	(Street a			Poute Number,				
5	VIVIAN HOWARD		#2	787	MARS:	HALI	HAL	L RO	DAD, B	RYANS	ROA	AD. M	IARYLAND2061
	20a, METHOD OF DISPOSITION 1 N Burlal 2 □ Cremation 3	Ramoval from State	20h DI ACE AN	DDATE	OF DISPOSI	TION /A/a	me of		DATE	20- 10	CATION	OM T-	04-4-
Į.	4 Donation 5 Other (Specific	y)	MARYLAI	V QV	ETER	ANS	CEM.	7/2	20/95	CHEI	TENH	HAM,	MARYLAND
	21. SIGNATURE OF FUNERAL SERV	ICE SICENSEE	Johns		22. N	IAME AN	ID ADDRES	IS OF FAC	CILITY RAL HO				
	LYDIA C. TH	HORNTON JOHN	SON M0058	33	#3	439	LIVI	NGST	CON RO	AD. TN	DTAN	J HEA	D,MD. 20640
	23. PART I. Enter the disease	s, or complications that	t caused the deet	h. Do r	not enter	the mo	de of dyl	ng, auch	h aa cardle	c or reapli	ratory ar	reat,	Approximata
	IMMEDIATE CAUSE (Finel												Interval Between Onset and Death
	diseese or condition resulting in death)	a. CAM	CER .		of		PRO	TLS	ATE	-			3-478-
ON	Sequentially list conditions,		OR AS A CONSEQUE									-	
¥	If any, leading to immediate cause. Enter UNDERLYING)	(OII AS A CONSECU	LINCE OF	7.								
Ħ	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSEQUE	ENCE O	F):								-
CERTIFICATION	resulting in deeth) LAST	d											
	PART II. Other algolficant con	nditions contributing to	death but not rea	ultino	n the une	dagladaa		lucan la f	Book I a				
MEDICAL			Security 100 100	uning	iii tire uik	Jerryring	cause g	iven in i	Part I. 24	PERFOR		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
									— ¹	YES 2	□ NO		DF DEATH?
	DID TOBACCO USE C	ONTRIBLITE TO CA	LISE OF DEATH	1 VE	S \square N	ΙΩ П	LINC	ERTAIN					1 TES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDI	CAL	26. PLACE				OIACI	CKIAII	4 🗀				
Sic	EXAMINER?	HOSPITAL:	ER/Outpatient 3 🗆	DOA	OTHER		5 PR	Idence	8 Other (S	inec/fv)			
	27. MANNER OF DEATH	28s. DATE OF (Month, Di		28b. TIM		28c. INJU	JRY AT		28d. DESCR		JURY OC	CURED	
BY	1 Natural 5 Pendin 2 Accident Investig	9	ay, comy	1140	M	1 🗌 Y	ES 2	NO					
	3 Suicide 8 Could	building,	F INJURY — At homa etc. (Specify)	, ferm, s	treet, facto	ry, offica			28f. LOCATIO	ON (Street a.	nd Numbe	r or Rural R	loute Number,
	4 Homicide datarm	Ined											
립		PHYSICIAN: To the best of											
COMPLET	one) 2 MEDICAL EX	CAMINER: On the basis of ax	ramination and/or invi	atigatio	n, In my op	Inlon, de	eath occurr	d at the t	time, data and	d placa, and	dua to ti	he cause(s) and manner as stated.
BE C	296. SIGNATURE AND TITLE OF CE	RTIFIER 1	10				29c. LICE	NSE NUM	BER		29d, DAT	E SIGNED	(Month, Day, Year)
TO B	pour	1/-1	60h			[> 7	7-1-	7-95
	30. NAME AND ADDRESS OF PERS	ON WHO COMPLETED CAUS	SE OF DEATH (ITEM 2	7) (Type,	Print)								
	24 DATE EN ED #4 Day 14												
	31. DATE FILED (Month, Day, Year)	1995 32. RESPITA	R'S SIGNATURE Diwelson Ro	W-11									
		7		men									

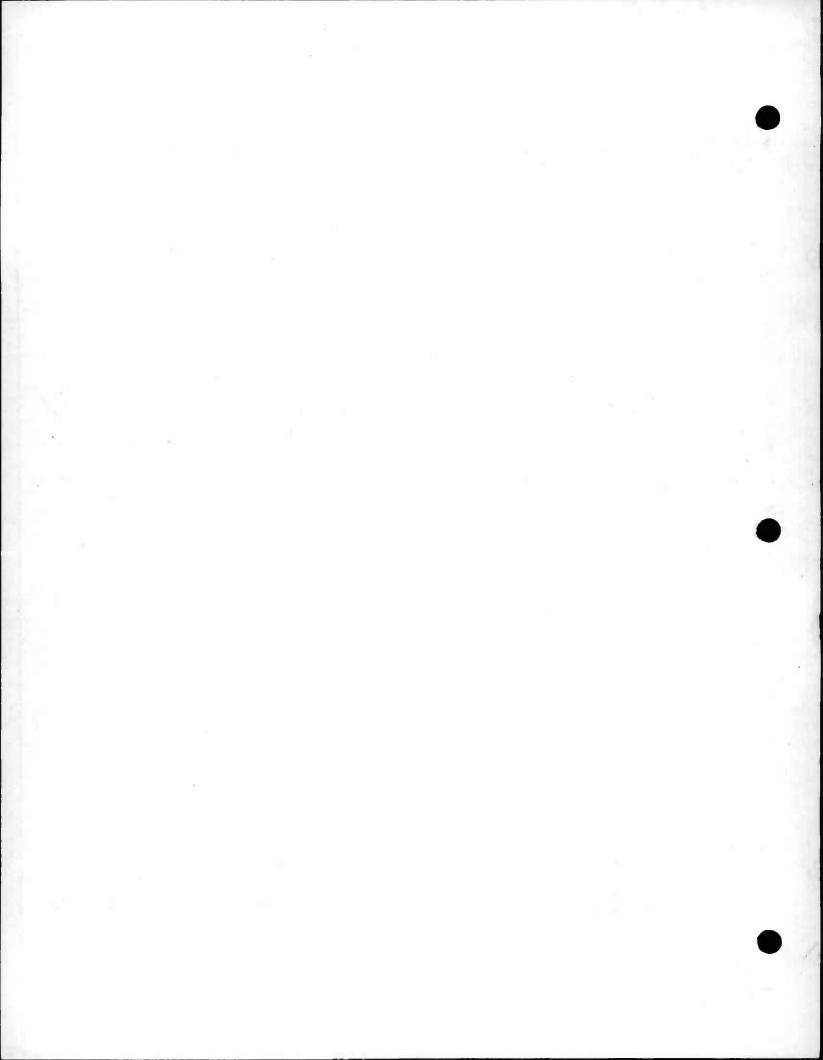


		FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTM CERTIFICA	ENT OF H	IEALTH AND DEATH		IYGIENE REG. NO.						
		DECEDENT'S NAME (First, Middle, Last)	Brendle	Horst			2. DATE OF MONTH July	DAY	YEAR 3.	TIME OF DEATH 9:03 P M				
Pir		4. SOCIAL SECURITY NUMBER 201-66-5053	1 🔀 M 2 🗌 F		UNDER 1 YEAR OTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF I	1980	Country)	yland				
, 2, 3 shor	TOR	99. FACILITY NAME (If not institution, give s Washington Count RESIDENCE OF DECEDENT		96.		rstown								
nit. Pages	DIRECTOR	10e. STATE 10b. COUNT	anklin		ynesbo					d. INSIDE CITY LIMITS? YES 2 1 NO				
an. ransit perr	FUNERAL		ollowell Chur		101	17268			S.A.	T COUNTRY?				
21215-0020 al or attending physicia for use as the burial-ti	В	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 — YES IF YES, GIVE WAR OR DA	2 X NO	If yea, sp	ecify Cuban, Maxic 2 NO Speci	Specific	American Indian, hite, atc. White						
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should notified at once.	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		18a. DECEDENT'S USU (Give kind of work life. Do NOT use ret Farm W	done during mo ired.)	DN st of working	Agriculture							
MARYLAND retained by the hospital S should be detached notified at once.	l w l	17. FATHER'S NAME (First, Middle, Last)	loyd E. Horst				AME (First, Middle, Malden Surname) 7 Jane Horst							
	TO B	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lloyd E. Horst 15986 Hollowell Church Rd. Waynesboro, Pa.												
E 6 mar ector, p		20b. PLACE ANDDATE OF DISPOSITION (Name of Later Share) 1 Densition 5 Other (Specify) 20b. PLACE ANDDATE OF DISPOSITION (Name of Cametery, requisitory or other place) Miller Symmetry, crematory or other place) Miller Symmetry or other Symmetry or other Symme												
		► H. Maitin	Zimnen	3~.	Zimm Gree	erman A	nd Son , Pa. 1	7225						
68760 wecuted with hourand completely filled I burial, cremation, or ratic event, the me	NO	23. PART I. Enter the diseases, preshock, prheart fellure. IMMEDIATE CAUSE (Final disease preportion resulting in death) Sequentially list conditions,	DUE TO (OR AS A	CONSEQUENCE OF):	*	da of dying, aud	ch aa cardiec	or respiratory arres	it,	Approximata Interval Between Onset and Death MINUTA				
P.O. BOX th certificate be e ending physician I Hygiene prior to or other traum	CERTIFICATION	If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	D	CONSEQUENCE OF):										
RECORDS, F we requires that the death is been signed by the attern of Health and Mental 3 shows any injury, of	MEDICAL	PART II. Other aignificent condition	e contributing to deeth bu	it not reaulting in th	e underlying	ceuse given in		PERFORMED? YES 2 NO	AVA CON OF	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION DF CAUSE DEATH?				
3 pp s		DID TOBACCO USE CONT		DEATH YES		UNCERTAI	Ν□		1 [YES 2 NO				
F VITA SICIAN: The Locatificate has the State Do I, or Item 2,	PHYSICIAN:	EXAMINER?	HOSPITAL:	_ ОТ	HER:	e 5 🗆 Rasidenca	6 Other (Sp	ecify)						
O FH state of	ву Рн	27. MÁNNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	M 1 Y	RK? 'ES 2 NO	Rescu	0.	a woll					
ATTEN ATTEN ECTOR: s after	ETED	Suicide 6 Could not be determined	28a. PLAČE OF INJURY - building, atc. (Specific	4 FAILS			Fred City or To	brist c	0	Number,				
로 정전 ==	COMPLET		CIAN: To the best of my knowless. R: On the basis of examination							f manner as stated.				
TO THE HOSPI TO THE FUNER be filed within IMPORTANT;	TO BE	296. SIGHATURE AND TURE OF SHITTERE	Calm			29c. LICENSE NUI		29d. DATE S	GIGNED (Mor	nth, Day, Year)				
	-	30. NAME AND ADDRESS OF PERSON WH	COMPLETED CAUSE OF DEAT	TH (ITEM 27) (Type, Print	on 14		Myon	5/0 Pm	luf)				
		JUE 2 6 1995" Jah	22. REGISTRANS SIGNA				/							



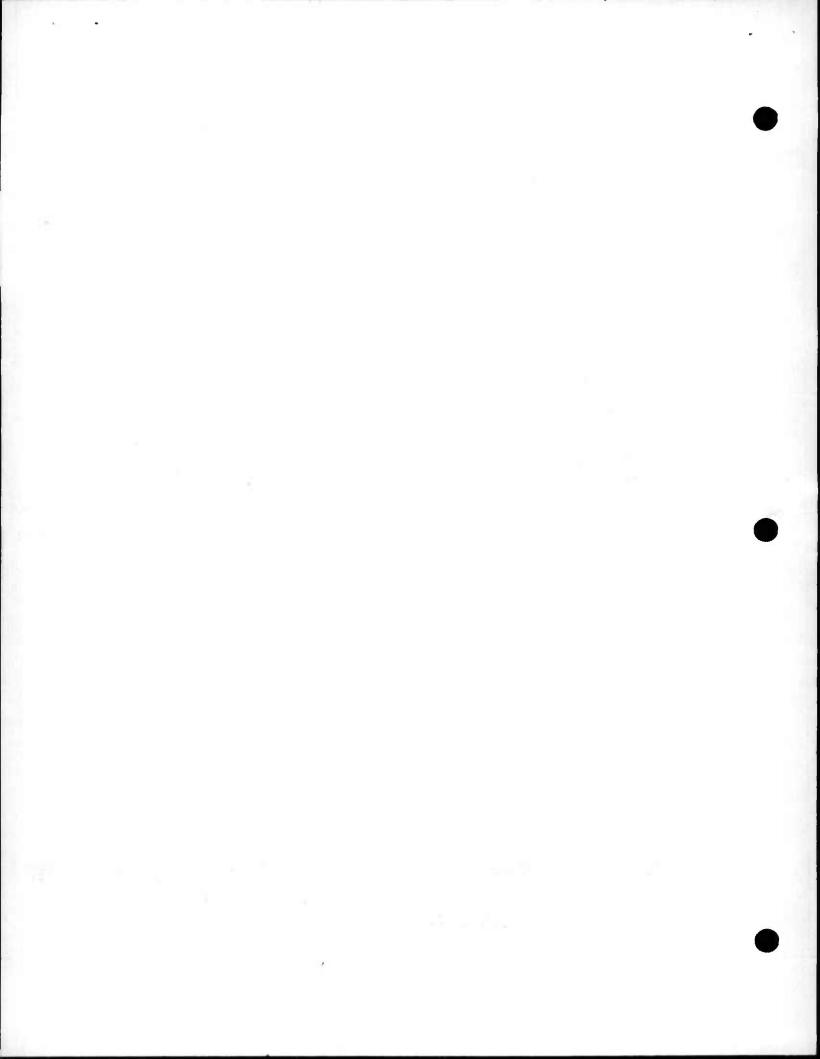
DIVISION OF VITAL RECORDS, P.O. BOX 68760

		REGISTRAN				CEI	KIIFI	CALE	: OF	DEA	IH		REG. NO			
		1. DECEOENT'S NAME (First		·	77.4	A 3 6 TT T						2. DATE O	F OEATH	AY	YEAR 3.	TIME OF DEATH
		Kei		amerson		AMILL						201	4 26		195	1,15 AM
		4. SOCIAL SECURITY NUME 214-28-0881		5. SEX	8. AGE	(In yrs. lest b		IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE Of (Month),	F BIRTH Day, Year)	1001	8. BIRTHPL. Country)	ACE (State or Foreign Virginia
pino		80. FACILITY NAME (If not in			<u></u>		Tho.	eh CITY	TOWN	OR LOCATION	ON OF DE		. 3,		West	
es Fis	E	Washington			·a1					rstow		AIR			shing	
2,	DIRECTOR	RESIDENCE OF DEC	EDENT											Wa	SHILIE	COII
Pages	끮	Mary land	10b. COUNTY				10c. CITY,	TOWN O							10	d. INSIDE CITY LIMITS?
Ē		Maryland 100. STREET AND NUMBER	Wa	shingtor	l .		Hagerstown 100, ZIP CODE 100, CITIZEN OF								YES 2 X NO	
U.Z.O. physician. burial-transit permit. Pages 1, 2, 3 should	RAL	918 Kenwoo	d Driv	re.					10		740			10g. CITIZ	U.S.	T COUNTRY?
ician.	FUNER.	11. MARITAL STATUS		12. WAS DECEOE!	IT EVER II	IN U.S. ARME	ED.	13. \	WAS DEC			IC ORIGIN?	(Specify Ver	or No		American Indien.
g physic		1 Never Married 2		FORCES?	MAR OR D	2 NO		1	yes, sp	ecify Cuba	n, Mexicar Specify.	n, Puerto Ric	cen, etc.)	01 110	Black, W Specify:	Thite, atc.
as the	р Ву	3 Widowed 4 Divo		1952-1	.955		whit							white		
use use		(Specify only	EDENT'S EDU	completed)		16e. DECE	e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)									
the hospital or attending physician detached for use as the burial-trar once.	COMPLETED	Elementary/Secondary (0 0-12	1-12)	College (1-4 or 5	+)		senior clerk					power company				
he hos detach		17. FATHER'S NAME (First, M	iddle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)									
ज के द	BE C	Law	rence	Hamill			Gladys Diehl									
s should notified	10 B	19a. INFORMANT'S NAME (7		b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
y be re sage 5	-	mis. Rimberry barnhart 950 Mt Aetha Road, nagerstown, Maryland										land	21740			
e 6 may be ector, page		20e. METHOD OF DISPOSITION 1 © Burlet 2 Cremetion 3 Removal from State 4 Donastion 5 Tother (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of competery, cremetory or other place) Cedar Lawn Memorial Park 7-25-95 Hagerstown N												State		
Page al dire		21. SIGNATURE OF FUNETIA		engle /		cedar	ematory or other place) ar Lawn Memorial Park 7-25-95 Hagerstown, Marylan 22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home								Maryland	
A hours after death. Page 6 may be filled in by the funeral director, page on, or removal.		1 / Shy	TA	12/2	1	4										, MD 21740
hours after ad in by the or removal medical		23. PART I. Enter the di	seases, or c	complications the	t caused	d the deati	h. Do no	ot enter	the mo	ode of dyl	ng, auch	aa cardia	c or respi	ratory arre	eat,	Approximata
filled I		IMMEDIATE CAUSE /Finel												Onset and Desth		
		resulting in desth)														
A 2 - 9	_	Sequentially list conditions b. //// Co/lepse 4 days													4 dout	
4 6 "OF	CATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												9 00/3		
physician physician ne prior t	SAT	cause (Disagne or Injury											Y doys			
certificate ding physi lygiene pr	E	that initiated events		DUE TO	(OR AS A	CONSEQUE	ENCE OF)	:								1
	CERTIFI	resulting in death) LAST														
the d We Injur		DATE II ON II-III III										RE AUTOPSY FINDINGS				
uires that signed by Health an	DICAL											_ ,			co	MPLETION OF CAUSE DEATH?
requires een sign of Healt	ME	1 U YES 2 @PNO OF										YES 2 NO				
as bept 23	Ä	DID TOBACCO U		RIBUTE TO CA		_					ERTAIN	1 1				
V: The law cate has t State Dept item 23	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		26. PLACE (T	OTHER	-							
SICIAN certific the S	HYS	1 VES 2 NO		1 Inpatient 2			DOA I			URY AT	sidence (6 Other (NJURY OCC	LIDEO.	
NG PHYS fter this cleath with	0.		Pending investigation	(Month, D			INJU		WO	PRK?	NO	200. DESC	NOE NOW II	NONT OCC	UNED	
ATTENDING PHYSICIAN: The CCTOR: After this certificate h s after death with the State (128 is marked, or item	р ву	2 - 6-4-4-	Could not be	26a. PLACE O	F INJURY	/ — Al home	, farm, str	reet, facto	ry, offic	•		281. LOCAT	ION (Street e	and Number o	or Rural Route	Number,
OR ATTENDING DIRECTOR: After hours after death Item 28 Is ma	ш.	4 Homicide	determined	Dullating,	with Jopet	<i>ыну)</i>						City or	Town, State)			
	COMPLE	29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowl	ledge, death	occurred	at the tir	ne, date	end place,	and due t	to the cause	(e) end men	ner es state	d.	
HOSPITAL FUNERAL WITHIN 72 TANT: If	Ö	one) 2 MEOI	CAL EXAMINE	R: On the basie of e	xaminatio	n and/or Invi	estigation	, In my op	elnion, d	leath occur	ed at the t	time, date er	nd place, en	d due lo lhe	ceuse(e) en	d menner es stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: II	ш	29b. SIGNATURE AND TITLE	F CERTIFIER	M	Λ.		-			29c. LICE	NSE NUM			29d. DATE	SIGNED (Mo	onth, Day, Year)
5 5 5 W	TO B	- J9/E	2	711				_		DY	728	38		>7	122/	95
		1) L9 Ba	PERSON WHO	1) Q h 1	SE OF DE	ATH (ITEM 2	7) (Type, F	- 4	-	- 1	11	9.0	1		-1	1 41000
		3 ICHE MEDAMA OF	tear) (la la	d Be THE CISTAIN	R'S'SIGN	ATURE	111	MU	CH	UC.	1	agre	240	wh	Mid	21740
		JUL # 4 1333	1000									4				



1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN YEAR 1995 Margaret Marv Hope July 16, 8:40 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday 7. DATE OF BIRTH
(Marth, Day, Year)
1 eb 13, 1909 IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTNPLACE (State or Foreign 215-74-7149 1 - M XX F 86 DAYS HOURS Pennsylvania Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 5910 Finchville-Reliance Road Rhodesdale Dorchester RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY
LIMITS?
1 YES 4-1 NO Maryland Dorchester Rhodesdale permit, FUNERAL 10e. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 5910 Finchville-Reliance Road 21659 US hours after death. Page 6 may be retained by the hospital or attending physician, 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES XX NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—if yee, specify Cuben, Maxican, Puerto Ricen, atc.)

1 YES Z.Z. NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES Specify: White ВҰ 3XXWidowed 4 Divorced COMPLETED 15. DECEOENT'S EQUCATION (Specify only highest grade complete 16s. DECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INOUSTRY entary/Secondary (0-12) College (1-4 or 5+) Homemaker 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) Joseph Jurasz Mary Fortein BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 Samuel E. Hope 5908 Finchville Reliance Rd Rhodesdale, Md 21659 pe 20s. METNOD OF DISPOSITION
1 Duriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State must Unity-Washington Cemetery 7/19 Donation § ☐ Other (Specify) Hurlock, Maryland examiner FUNERAL SERVICE LICENSEE 21. SIGNATURE / 22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home, P.A. 700 Locust St. Cambridge, ton n by the fremoval. Md. 21613 medical 23. PARTM. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. filled in by Approximata Interval Batween 0 **IMMEDIATE CAUSE (Final Onset and Death** and completely fille burial, cremation, event, the disease or condition_ HOENDCURCINOMO rectal month reaulting In death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): executed other traumatic NOI Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to if any, leading to immediate cause. Enter UNDERLYING signed by the attending physician and Mental Hygiene prior to death certificate be CERTIFICAT CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that Initiated events resulting in dasth) LAST 6 injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. law requires that the MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? any 1 - YES 2 NO shows a 1 TYES 2 NO t. of h PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO 🔀 has b. Dept. UNCERTAIN [23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) DIRECTOR: After this certificate ha hours after death with the State Di HOSPITAL: 1 TES 2 NO 1 - Inpatient 2 - ER/Outpatient 3 -4 - Nursing Nome 5 Residence 8 - Other (Specify) 6 27. MANNER OF CEATN 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. OESCRIBE NOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 28a. PLACE OF INJURY — At home, farm, atreet, fectory, office building, stc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .00 8 Could not be 4 Nomicide 28 COMPLET Item 29e. CERTIFIER 1 😿 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner se stated. HOSPITAL [FUNERAL [Within 72 h (Check only one) = TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT; II 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATN (ITEM 27) (Type, Print) Rosemary M. Harris, MD 408 Byrn St. Cambridge MD 21613 M. REGISEBAR'S SIGNATURE LOLL 31. DATE FILED (Month, Day, Year) 2 0 1995



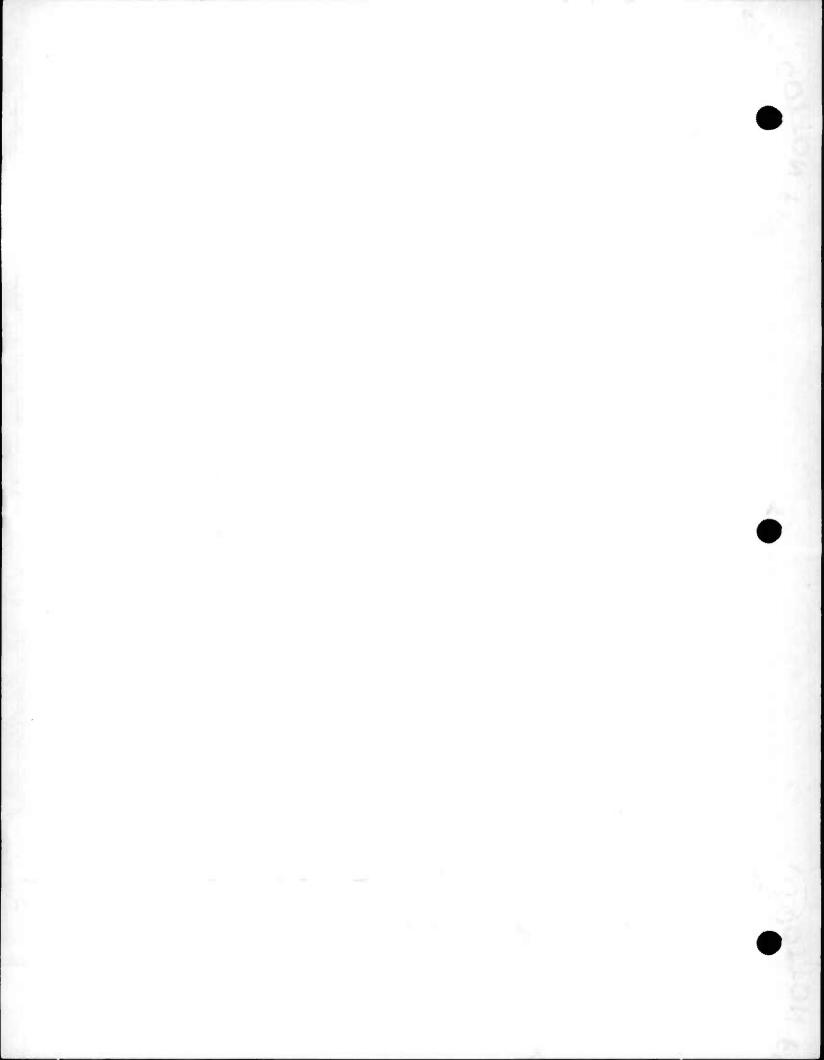
BALTIMORE, MARYLAND 21215-0020	us after death. Page 6 may be retained by the hospital or attending physician,	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	
OF VITAL RECORDS, P.O. BOX 68760 & BALTIMORE, MARYLAND 21215-0020	PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician,	this certificate has been signed by the attending physician and completely filled in by the I with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.	

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attention physician and completely filled in by the funeral director, page 5 should be defacthed be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

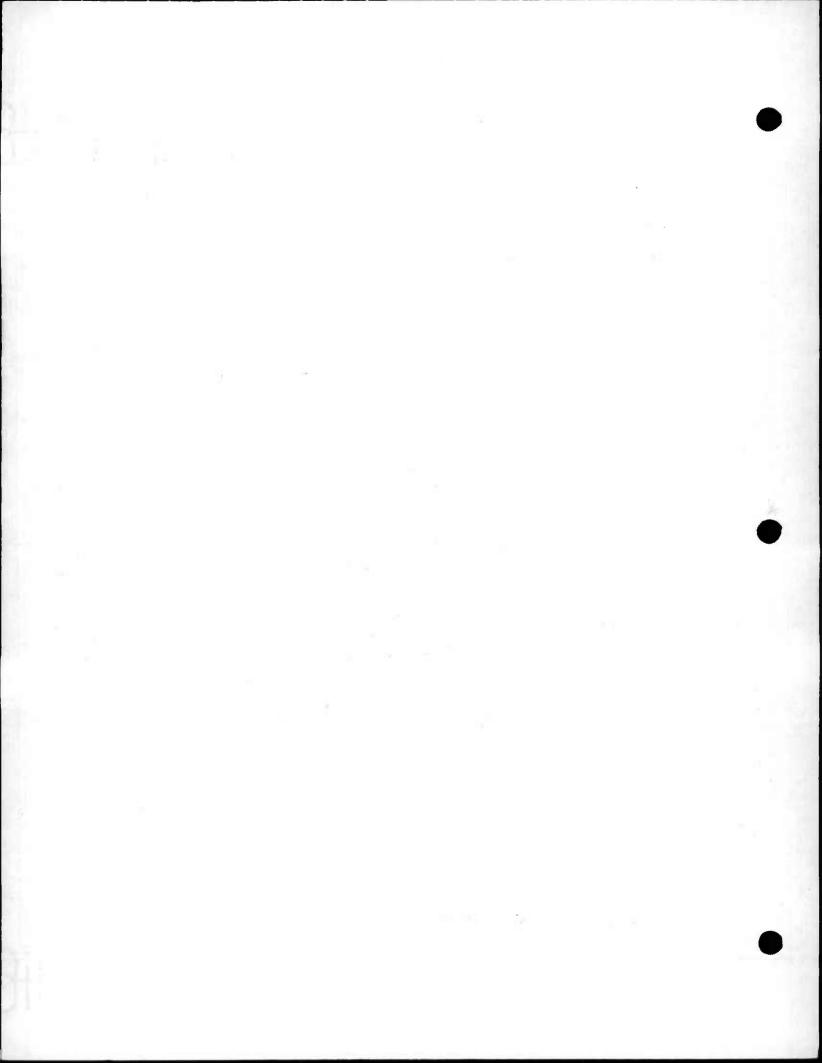
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTM CERTIFICA			MENTAL HYG					
()	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEA	ΓN	3. TIME OF DEATH			
	MICHAEL	JANIFER				JULY	17, 19	YEAR			
100				UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRT	н	8. BIRTHPLACE (State or Foreign			
	220-42-1257 9e. FACILITY NAME (If not institution, give stre		± / YRS.	CITY TOWN C	HOURS MIN.		0,1947	WASH., DC			
DIRECTOR	5412 QUESADA R				VERDALI		131 132	CE GEORGE'S			
EC	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c, CITY, TO	WN OR LOCAT	ION	10d. INSIDE CITY					
DIR	MARYLAND PRINCE	GEORGE'S	RIV	ERDAL	E			LIMITS?			
	10e. STREET AND NUMBER		ZIP CODE		10g. CITIZ	CITIZEN OF WHAT COUNTRY?					
ÉR	5412 QUESADA RO	AD			2073	37		USA			
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 M Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 XNO	If yes, spe	ENDENT OF NISPAI city Cuban, Maxica 2 NO Specif	NIC ORIGIN? (Speci in, Puerto Rican, ato y:	ly Yee or No-	14. RACE — American Indian, Black, White, etc. Specify:			
	(Specify only highest grade or Elementary/Secondary (0-12)		(Give kind of work life, Do NOT use ret	done durina mos		180. KIND O	r BUSINESS/INDU	ISTHY			
P	9th	College (1-4 or 5+)	BUS O	PERAT	OR		PVT				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, M					
BE (PHILIP S. JA	NIFER		_	LAV	ERNE B					
10	19e. INFORMANT'S NAME (Type/Print)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
_	GAIL McDUFFEY	/ SISTER	3245 W.	ALNUT	ST. NE	WASH	INGTON	, DC 20018			
	20a. METHOD OF DISPOSITION 1) Duriel 2 Cremellon 3 Remov	al from State 20b.	PLACE ANO DATE OF DI	SPOSITION (Nai	ne of)	c. LOCATION — C				
	4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE!		I. LINCO.					TWOOD, MD			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY J. B. JENKINS FUNERAL HOME 20785 7474 LANDOVER ROAD LANDOVER, MD										
NOI	23. PART I. Entar the diseases, or co ahock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	METAST DUE TO (OR AS A	ich Ilna.			A A		Interval Between			
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):								
CAL	PART II. Other significant conditions	contributing to death bu	at not resulting in th	e underlying	cause given in	PE	S AN AUTOPSY REFORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF GEATH?			
PHYSICIAN: MEDI				1	/			1 YES 2 NO			
ä	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	F DEATH YES	□ NO □	UNCERTAIL	V 🗆					
CIA	25. WAS CASE REFERRED TO MEDICAL. EXAMINER?	HOSPITAL:	8. PLACE OF DEATH (C	<u>_</u>	. /						
YSI	1 TES 2 TAO	I ☐ Inpatient 2 ☐ ER/Oulpe				6 Other (Specify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJU	RK?	28d. DESCRIBE N	OW INJURY OCCU	JRED			
В	2 Accident Investigation	28e. PLACE OF INJURY	Al home form street		ES 2 NO	204 1 00471011 (0					
TED	3 Suicide 8 Could not be determined	building, etc. (Special	fy)	, rectory, office		City or Town,	ION (Street end Number or Rural Route Number, Town, State)				
COMPLETED		AN: To the best of my knowle On the basis of examination						d. ceuse(e) end manner se stated.			
ш	296. SIGNATURE AND TITLE OF CERTIFIER	0	Δ.	,	29c. LICENSE NUI	ABER	29d. DATE	SIGNED (Month, Day, Year)			
TO B	Kabliem	Marin	u 17	∇	D36	146	•	7-19-9			
	30, NAME AND ADDRESS OF PERSON WHO WATHERINE	TKACZL	TH (ITEM 27) (Type, Print		SouTi	4 GREE	ENE ST	- BALTIMORE			
	JUL 20 1995	32 APPGISTRAP'S SIGNA	Mardall)							



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	the attending	ntal Hygie
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF HE		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)	MISSOL	JRI JONES			2. DATE OF DEATH MONTH 12		3. TIME OF DEATH 7:00 A M
	579-32-8466	1 □ M 2 ½ F 8			IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign Country) (alifax Co., NC
TOR	99. FACILITY NAME (If not institution, give street Prince Georges Ho RESIDENCE OF DECEDENT			96. CITY, TOWH OR Chev	erly	ATH	9c. COUNTY	of DEATH e George's
DIRECTOR	100. STATE 100. COUNTY District of Columb	ia	10c. CITY,	TOWH OR LOCATIO				10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	10. STREET AND NUMBER 268 56th Place, N			10f. Z	IP CODE 0019		_	of what country?
B⊀	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, speci	DENT OF HISPANI fy Cuben, Mexican NO Specify:	C ORIGIN? (Specify Yes , Puerto Rican, etc.)	or No- 14.	RACE — American Indian, Black, White, etc. Specify: Black
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	TION Impleted) College (1-4 or 5+)	life. Do NOT use	rk done durina most		16b. KINO OF BUS		FRY
BE COM	17. FATHER'S NAME (First, Middle, Last) Grant Worsley		1002100		8. MOTHER'S NAM	ME (First, Middle, Maiden :		
10	190. INFORMANT'S NAME (Type/Print) Dallas L. Barnes					oute Number, City or Yowr ,#202, Sui		
	20a. METHOD OF DISPOSITION DISPOSITION DISPOSITION OF DISPOSITION	al from State ceme	PLACE AND DATE OF tery, cremetory or othe .ncoln Me	morial P		7/17/95 Su		or Town, State , Maryland
	John T. S.	towart.	11/	STEWAR 4001 B	I FUNERA enning H	AL HOME Road, N.E.	,Washi	ngton, D. C.
	23. PART I. Enter the diseases, pr cor shock, or heart failure. Lis IMMEDIATE CAUSE (Final disease pr condition resulting in desth)	Severe (Due to (OR AS A CANA)	ch ilne.				ratory arrest,	Interval Between Onset and Death
CATION	If any, leading to Immediate cause. Enter UNDERLYING	DUE TO (OR AS A	y and consequence of):	ery o	lescon	2		1 Mmin
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in desth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
PHYSICIAN: MEDICAL	PART II. Other significant conditions of	contributing to death bu	t not resulting in	the underlying o	auae given in F	Part I. 24a. WAS AN PERFORI	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
IAN: N	DID TOBACCO USE CONTRIE		DEATH YES		UNCERTAIN			1 YES 2 NO
HYSIC		IOSPITAL: Inpetient 2 ER/Outpar 28e. DATE OF INJURY		OTHER: Nursing Home OF 28c. INJUR	7	Other (Specify) 28d. DESCRIBE HOW IN	ILIPY OCCUPE	
à l	1 Netural 5 Pending Investigation 3 Suicide a Could not be	(Month, Day, Year) 28e. PLACE OF INJURY - building, etc. (Specif	- At home, farm, atr	M 1 YES	? 2 🗆 NO	28f. LOCATION (Street o		
COMPLETED	4 Homicide determined	AN: To the best of my knowle		at the time, date en	d place, and due to	City or Town, State)	nor on stated	
				In my opinion, deat		lme, date end place, end	d due to the ce	use(e) end manner ee stated.
TO BE	30, NAME AND ABORESS OF PERSON WHO C	COMPLETED CAUSE OF DEAT	Г Н (ITEM 27) (Туре, Р		DIRIO	4	▶ 7/	DED (Mogth, Day, Year)
	6005 LANDOVAS	ROAD GH	EVERLY	Mn2	0785	<u> </u>		
	JUL 20 1990	E			····			



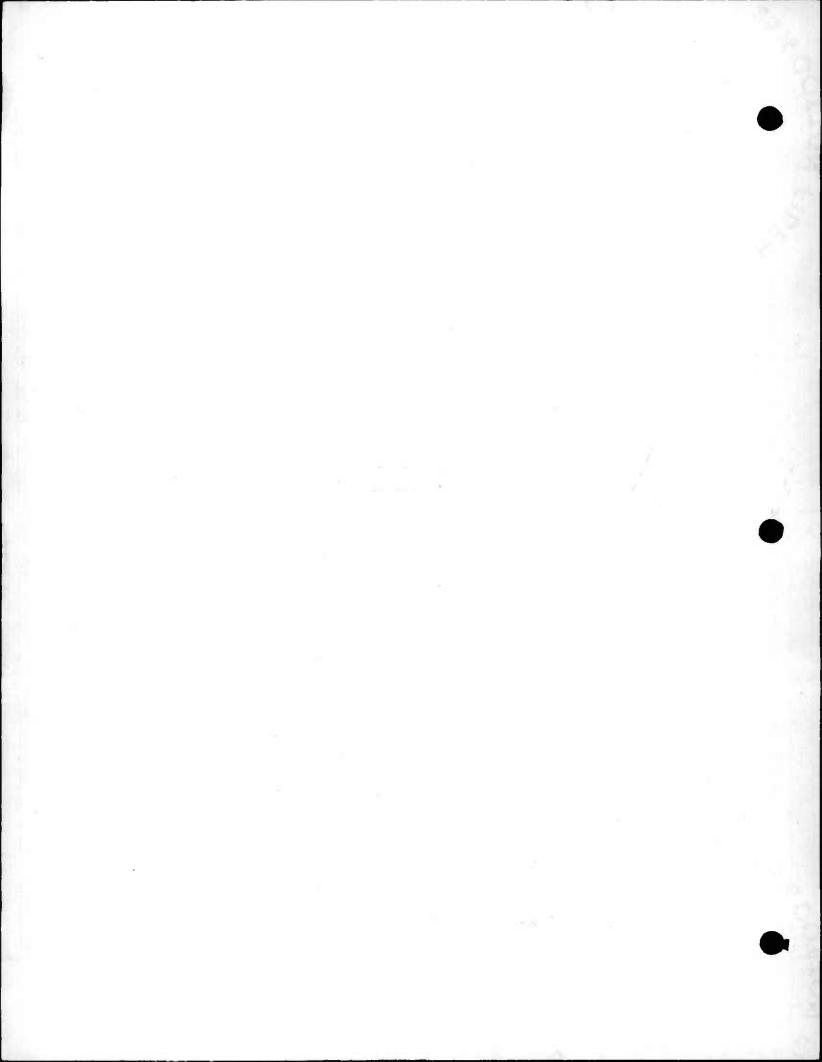
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

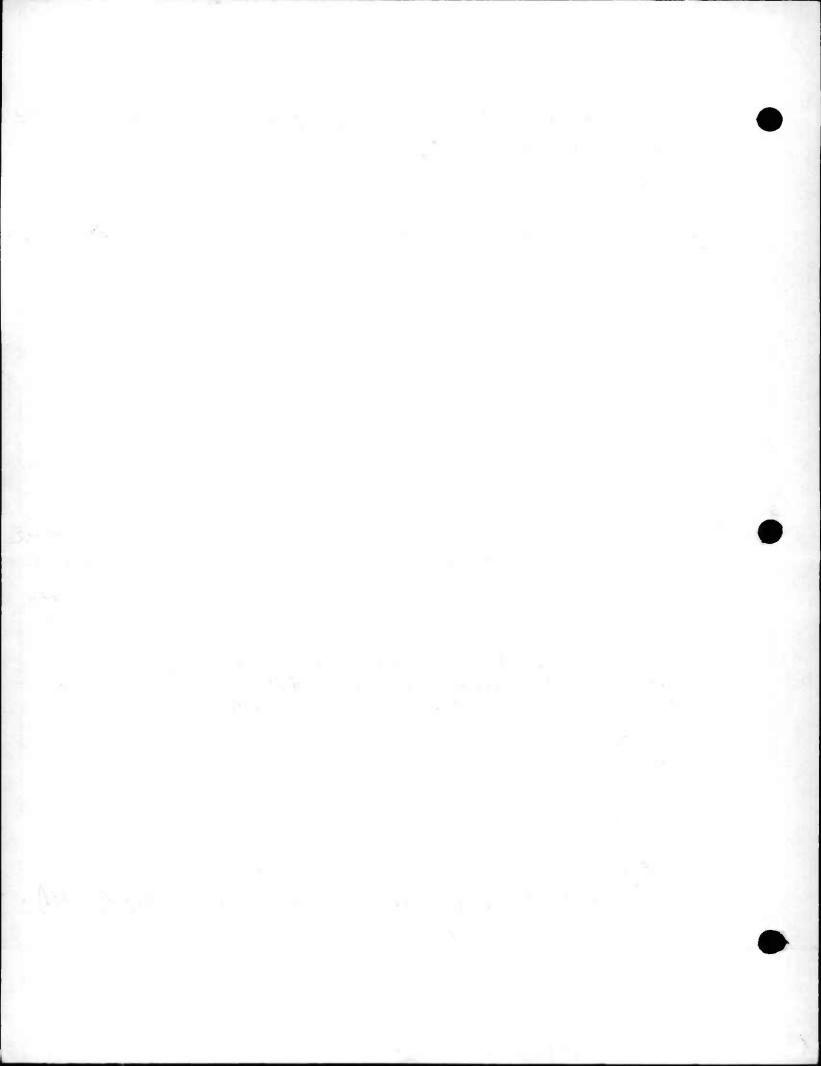
	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	ENT OF HEALTH	AND ME	NTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)			OI DEA	2.	DATE OF DEATH		3. TIME OF DEATH
	ALBERT	E JC	HNSTON			MONTH DA	1995	10 05P M
	4. SOCIAL SECURITY NUMBER		yrs. last birthday) IF			DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign
	577-14-5065	1 💢 M 2 🗆 F 8	5 YRS.	THE DAYS HOURS		(Month, Day, Year) anuary 20.	1910 Coun	Charlotte NC
_	9a. FACILITY NAME (If not institution, give stre	set end number)	96	CITY, TOWN OR LOCAT			9c. COUNTY OF	
DIRECTOR	Prince George's	Hospital Cen	ter	Cheve	erly		Prince	George's
EC	10a. STATE 10b. COUNTY		10c, CITY, TO	WN OR LOCATION				10d. INSIDE CITY
DIA	Maryland Pri	nce George's		Largo)			LIMITS?
AL	100. STREET AND NUMBER			10f. ZIP COO			10g. CITIZEN OF	WHAT COUNTRY?
BY FUNERAL	9610 Cedar Ho	llow Lane			20772		Unit	ed States
5		12. WAS DECEDENT EVER IN 1 FORCES? 1 YES	U.S. ARMED	13. WAS DECENDENT	OF HISPANIC O	RIGIN? (Specify Yes	or No- 14. RAC	E — American Indian, k, White, atc.
λ.	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	ES	If yes, specify Cub 1 - YES 2 X NO		uerto Hican, etc.)	Spec	offy:
	15. OECEDENT'S EDUCA	ATION	18e. DECEDENT'S USU	A. 000/10/10/10		I		Black
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted)	(Give kind of work life. Do NOT use re	done during most of work	ing	186. KIND OF BUS	SINESS/INDUSTRY	
P.	12th	College (1-4 or 5+)	Dry Cle	aning Pres	sser	-	Private	
Ö	17. FATHER'S NAME (First, Middle, Last)					First, Middle, Maiden		
BE C						, , , , , , , , , , , , , , , , , , , ,	,	
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING ADI	ORESS (Street and Number	or or Rural Route	Number, City or Town	n, State, Zip Code)	
۲	Terry D. Jo	hnston	9610 0	edar Hollo	ow Lane	, Largo	, MD 20	772
	20e. METHOD OF DISPOSITION 5 Burlel 2 Cremetion 3 Remov		LACE AND DATE OF D				CATION — City or To	own, State
	4 Dorlation 5 D Other (Specify)		incoln Memo	rial Cemeter		0/95	Suitlar	nd, MD
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE A		22. NAME AND ADDRE	SS OF FACILIT	Y Stewa	rt Funer	al Home
	18/m T.	Slever	111	4001 Benr	ning Rd	l., N.E.	Wash., D	.C. 20019
	23. PART I. Enter the diseases, pr co shock, pr heert fallure. Li	mplicetions that caused ist only one ceuse on each	the deeth. Do not o	enter the mode of dy	ring, auch ea	cardiac or reapli	ratory arrest,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition	Encopy	alera	stry	LLUA	-1016		Onset and Death
	resulting in deeth)	DUE TO (OR BS A C	CONSEQUENCE OF		DABO	OXIC.		>4- man
_		Rosain N	atery	FOI	Lin	2.		Ju-monte
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO TOR AS A C	ONSEQUENCE OF	1	-	4	0	77.10
CA	CAUSE (Disease or injury	CVD)-chr	2001 C-012	Smi	live-pa	Mound	04. (
TE	that initiated events resulting in death) LAST	DUE TO (ORTAS A C	ONSEQUENCE OF):			U	out of	
HH	residing in death) Exs	C HT						1
AL C	PART if. Other aignificant conditions	contributing to death but	not reaulting in th	q underlying sause	given in Part	i. 24s. WAS AN	AUTOPSY 248	. WERE AUTOPSY FINDINGS
	D'abeter 1	rethty;	TLOC	herstor	my,		MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	He wa	S DNR.	SOP	eie.		1 🗆 YES 2	XYO	DF DEATH?
7	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF	DEATH YES	□ NO □ UNO	ERTAIN D	4		1 VES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	20	. PLACE OF OEATH (C					/ //
SIC	1 VES 2 XXIO	IDSPITAL:		HER: Nursing Home 5 - R	esidence 6 🗆	Other (Specify)		
E	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28s. INJURY AT WORAT	28d	DESCRIBE HOW IN	JURY OCCURED	
BY	1 Natural 5 Pending 2 Accident Investigation			and the second second	□ NO		-	
	3 Suicide 8 Could not be	28s. PLACE OF MUSICY - building: str. (Specify	At home, farm, stree	effory, office	281.	LOCATION (Street at City or Town, State)	nd Number or Rural	Route Number,
	4 Homicide determined		-					
P	29e. CERTIFIER Check only	AN: To the bast of my knowled	ige, death occurred at	the time, date and place	, end due to th	ne cause(e) end meni	ner ee atated.	
COMPLETED		On the basis of examination of						e) end menner ee stated.
BE C	296. SIGNATURE AND TITLE OF CERTIFIE	7000	- ^	29c. LIC	ENSE NUMBER	8	29d. DATE SIGNED	(Month, Day, Year)
	i i	0000	W	D-3	342	25	107-	15-95
٩	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEAT	H (ITEM 27) (Type) Print	Ala Pas	dit	990.	201 215	110.0-11
	- on hour c	1000 -100	1 const	ME LAR	ILL / T	000	somit.	10108 Ch
	31. DITE 20 1995" AL	327 EGISTE APPRICAL						



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BALLIMORE, MARYLAND 212	w requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or a	
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HECORDS, P.O. BOX 68760	execute	
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN 7 1500 8. BIRTNPLACE (State or Foreign Country) 6. AGE (In yrs. last birthday YRS. 5. SEX 7. DATE OF BIRTN (Month, Day, Year, IF UNDER 1 YEAR 1 M 2 | F DAYS HOURS March 9 Maryland 1906 Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF GEATH DIRECTOR Meridian Health Care Center Spa Creek Anne Arundel Annapolis RESIDENCE OF DECEDENT 10h COUNTY 10d. INSIDE CITY Anne Arundel Annapolis 1 X YES 2 NO burial-transit permit. FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 219 Claude Street 21401 United States 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—II yea, specify Cuban, Mexican, Puerto Rican, atc.) 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married 1 TES 2 NO Specify: BY Specify: White 3 Widowed 4 Divorced use as the WWII COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Sn JO. Elementary/Secondary (0-12) College (1-4 or 5+) 4 Editor Newspaper 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) notified at Elmer M. Jackson Blanch B. Bower BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Doris G. Jackson 219 Claude Street Annapolis, MD 21401 pe 20a METHOD OF DISPOSITION
1 Quriel 2 Cremation 3 Ramoval from State 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Anne's <u>Cemetery</u> 4 Donellon 5 Other (Specify) 7/19/95 Annapolis, Maryland medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ACCRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD the 23. PART I. Enter tha diseases, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, ahock, or heart failure. List only one cause on each line. interval Between Onset and Death ŏ IMMEDIATE CAUSE (Final cremation, the disease or condition Grebra Edama reaulting in death) injury, or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF bunal, CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF) prior to if any, leading to immediate elrosote cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 23 shows any signed Health a 1 YES 2 NO OF DEATH? 1 TYES 2 NO of s certificate has be th the State Dept. PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES DIVISION OF VITAL 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) Rem OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 0 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATN 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED this c marked, 1 Vatural 1 YES 2 NO BY DIRECTOR: After the hours after death item 28 is mark 2 Accident 28s. PLACE OF INJURY — Al home, larm, streel, factory, offica building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER PRYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated.

MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the course of TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 HORIMANT: IF IN SIGNATURE AND FITLE OF CERTIFIER 29d. DATE SIGNED (Mor 29t. LICENSE NUMBER BE 2 WNO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) REGISTRAR'S SIGNATURE Davidson Randall



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH Ridi Jones Maria July 1995 16 10A A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year, 6. BIRTHPLACE (State or Foreign HOURS 577-30-2580 YRS. Dec 31 1912 Austria permit. Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 420 DuVall-Road LANE DIRECTOR Anne Arundel Annapolis RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Anne Arundel MD Annapolis 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 21403 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? X 68760 Baltin B 420 DuVall-Road LANE 21401 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES NO IF YES, GIYE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) BY 1 TES NO Specify: Specify White Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) 12 Salesperson Retail 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Johann Wasserbacher MARIA SALZER H 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 3109 Virginia Avenue Silver Soring, MD 20910 Hilda Buffington 9 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must Ft. Lincoln Crematory 7/17/95 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland examiner 21. SIGNATURE OF TUBERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD DEXAM medical 23. PART i. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate ahock, or heart feiture. List only one cause on each line. **IMMEDIATE CAUSE (Finel** Onset and Death the disease or condition ardiac arrest resulting in death) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 itay desiase . = CHF requires that the death certificate be executed traumatic CERTIFICATION Sequentially list conditions, if any, leeding to immediate the attending physician | Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in daeth) LAST 0 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. n signed by th MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 - YES 2 NO been s 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: HOSPITAL DR ATTENDING PHYSICIAN: The law is FUNERAL DIRECTOR: After this certificate has be within 72 hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) tem HOSPITAL: 1 TYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, t Naturel
2 Accident 5 Pending Investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, larm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 8 Could not be 4 Homicide 28 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner se stated. TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 HORIZANT: If IN (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the ilime, data and place, and due to the cause(s) and manner as stated. 296 SIGNATORE AND TITLE OF CERT 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D01030 ▶07/17/95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2083 West St., 2A, Annapolis, MD 21401 William H. Choate, M.D. 31. DATE FILED (Month, Day, Year)

JUL 18 32. REGISTRAR'S SIGNATURE PORTAL 1995

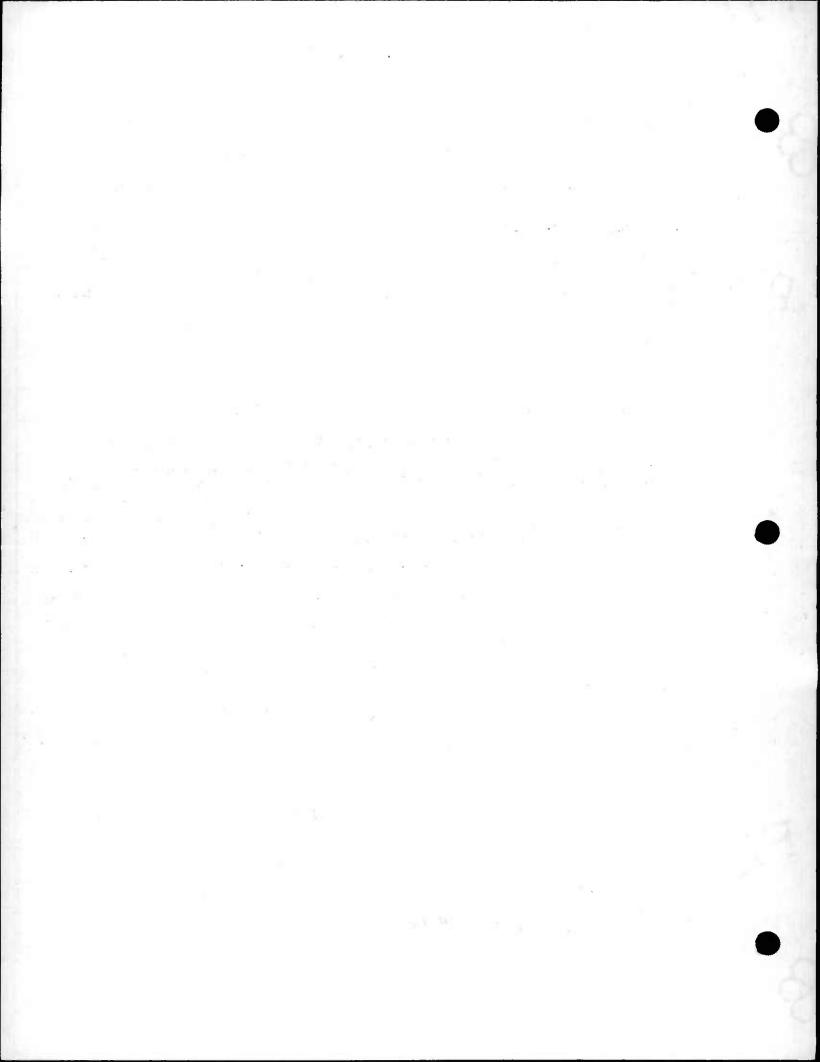
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68769

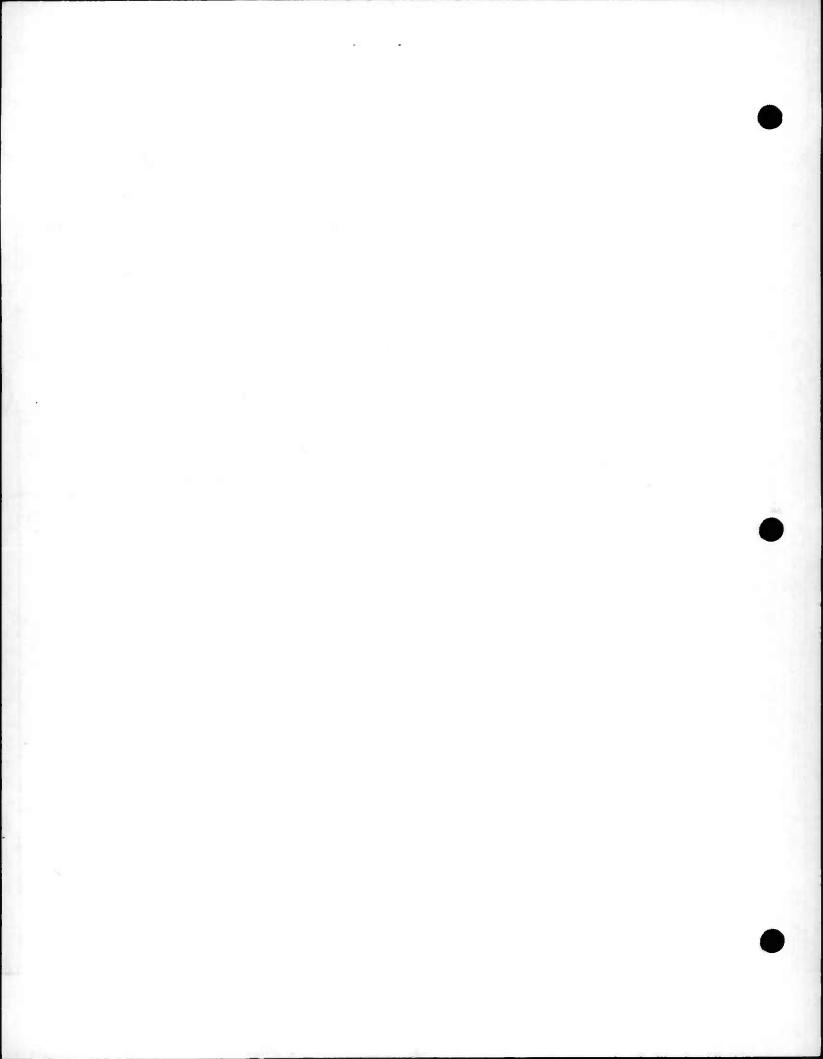
FOR 1 - STATE

	REGISTRAR		CERTIF	ICATE O	F DEATH	REG. NO.		
- 1	1. DECEDENT'S NAME (First, Middle, Last)	, -				2. DATE OF DEATH		3. TIME OF OEATN
, j	Erma Jones	na Vi Joi	nes				NY YEAR 95	0545 а м
- 8			s. lest birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTN (Month, Day, Year)	8. BIRTH	IPLACE (State or Foreign
		1 □ M 2 🗓 F 85	YRS.	MONTHS DAYS	HOURS MIN.	06/09/10	MAR	YLAND
-3	9e. FACILITY NAME (If not institution, give street	et and number)		9b. CITY, TOW	OR LOCATION OF D	EATN	9c. COUNTY OF D	
DIRECTOR	St. Joseph Medical	Center		BALT	IMORE		BALTI	MORE
E I	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOC	ATION			10d. INSIDE CITY
뜽	MARYLAND BAL	TIMORE	100	BALTIM				LIMITS?
	10e. STREET AND NUMBER	TIMORE			IOF. ZIP CODE		10g. CITIZEN OF	1 X YES 2 NO
FUNERAL	7827 PERRY ROAD				21236	-	,	
3		2 WAS DECEDENT THEN IN U.S.	. ARMEO	13. WAS D		NIC ORIGIN? (Specify Yes	US or No. 14 BACI	A — American Indian,
	1 X Never Married 2 Merried	FORCES? 1 YES 2	XNO	If yes,	specify Cuben, Mexico	en, Puerto Ricen, etc.)	Black	k, White, etc.
BY	3 Widowed 4 Divorced			1		,	3,000.	» WILLE
Ë	15. DECEDENT'S EDUCAT (Specify only highest grade col	TION 16st mpleted)	(Give kind of t	USUAL OCCUPA	TION nost of working	16b. KIND OF BUS	SINESS/INDUSTRY	
"		College (1-4 or 5+)	life. Do NOT us	se retired.)				
COMPLETED	3		NEVE	ER WOR	KED			
8	17. FATHER'S NAME (First, Middle, Last) THOMAS HARRY JO	NEC				ME (First, Middle, Maiden		
BE	19a. INFORMANT'S NAME (Type/Print)	NES				IA HUDNAL		
2	BARBARA A. KELL	A M				Ploute Number, City or Town		226
	200. METHOD OF DISPOSITION					BALTIMORE		
İ	1 N Burial 2 Cremation 3 Remova			of oisposition (7-21 STE	CATION — City or To	
į	21 SIGNATURE OF FUNERAL SERVICE LICEN	SEE						
	MEDOWN	que The CF	CA	NEW	NAM FUNE	ERAL HOME	,P.A.	
				200	S. HARI	RISON ST.	, EASTO	N, MD
	23. PART I. Enter the diseases, or con shock, or heart failure. Lis	nplications that caused the	death. Do r	ot enter the n	noda of dying, auc	h as cardiac or reapi	ratory arreat,	Approximata interval Between
	IMMEDIATE CAUSE (Final	S TO S TO A SECURE OF STREET						Onset and Death
	disease or condition resulting in death)	Intestinal i						1 WEEK
		DUE TO (OR AS A COM		*				
NO N	Sequentially list conditions, b.	Stenosis of			enteric a	rtery		MONTHS
CERTIFICATION	if any, leading to immediata cause. Enter UNDERLYING)		•				
윤	CAUSE (Disease or injury that initiated events	Atheromatous	S_CALCI	tic pla	aque			YEARS
E	resulting in death) LAST	Advanced aor						YEARS
	0							
EDICAL	PART ii. Other significant conditions of	contributing to death but n	ot reaulting i	n the undarly	ng cause given in	Part i. 24a. WAS AN. PERFOR		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ä	1) Brain infarcti					1 X YES 2	□ NO	COMPLETION OF CAUSE DF DEATH?
Σ	2) Aortic valve e					_ [1 X YES 2 - NO
ÿ	DID TOBACCO USE CONTRIE					N 🗆		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. F	LACE OF DEAT	N (Check only on OTHER:	9)			
XS	1 YES 2 NO 1	XInpatient 2 - ER/Outpatian	8 3 🗆 DOA		me 5 🗆 Residence	6 C Other (Specify)		
E	27. MANNER OF DEATH 1 X Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM INJ		JURY AT	28d. DESCRIBE NOW IN	JURY OCCURED	
À !	2 Accident Investigation				YES 2 NO			
	3 Suicide a Could not be 4 Homicide determined	28e. PLACE OF INJURY — A building, etc. (Specify)	t home, farm, a	treat, fectory, of	Ice	28f. LOCATION (Street a City or Town, State)	nd Number or Rural R	loute Number,
COMPLETED	29a. CERTIFIER (Check only 1 X CERTIFYING PHYSICIA	N: To the best of my knowledge	, death occurre	d at the time, da	te end place, end due	to the cause(s) end men	ner ee atated.	
Š I		On the beals of exemination end	/or Investigatio	n, in my opinion,	death occured at the	time, date end place, and	due to the cause(e	end manner ee stated.
ш	296. SIGNATURE AND THE OF CERTIFIED	14	7		29c. LICENSE NUI	MBER	29d. DATE SIGNED	(Month, Day, Year)
10 B	(.19)	1. 6	1. 17		D131	40	▶ 07/18	/95
٦	30. NAME AND ADDRESS OF PERSON WHO C							
	Reynaldo Ofjuela-			ork Roa	ad Towso	n, Md 21	1204	
	31. DATE FILED Month, Day Mear)	32. REGISTRAR'S SIGNATUR	El II.					
- 1	1111 2 0 1995	The Eleveryson of	CONTRACT OF THE PERSON OF THE					



STATE OF MARYLAND / DEPARTMENT OF HEALTH AN	D MENTAL HYGIENI
CERTIFICATE OF DEATH	BEG NO

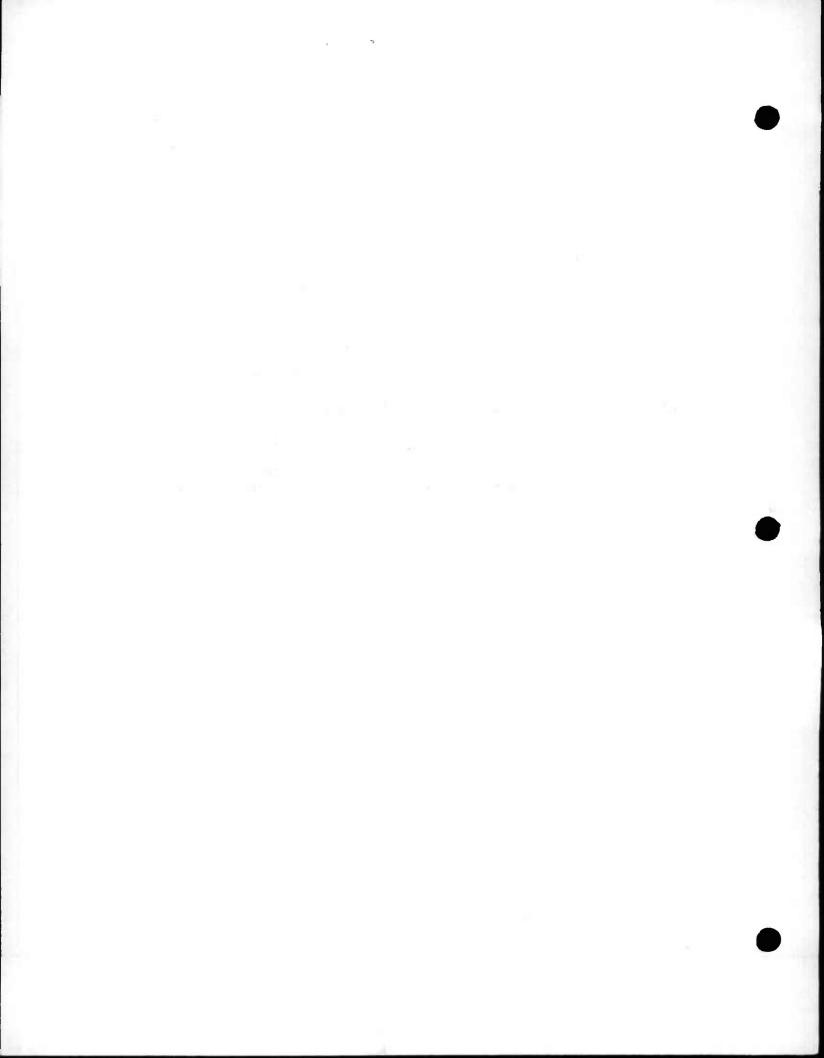
		FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIFI	TMENT OF I	HEALTH AND		HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF	DEATH	V548	3. TIME OF DEATH	
		Robert	Stanley		on, Sr.		June	30, 1	995	8:20 AM	M
P		4. SOCIAL SECURITY NUMBER 216-03-7511	1 🔯 M 2 🗆 F 8	(In yrs. last birthday) 7 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, D	26, 1908	8. BIRT Coun Peni	HPLACE (State or Foreign try) Osylvania	
2, 3 should	FOR	9a. FACILITY NAME (If not institution, give 112 West Ja RESIDENCE OF DECEDENT		Road	9b. CITY, TOWN	Forest I		9c. C	OUNTY OF	oeath arford	
Pages 1,	DIRECTOR	10a. STATE 10b. COUNT			, TOWN OR LOCA	TION				10d. INSIDE CITY	_
permit. Pa		MARYLAND TAI	BOT		WYE M	ILLS		Direction of the last of the l		LIMITS?	
Si	FUNERAL	12612 WYE LANE				2167		34.5	U	WHAT COUNTRY?	
or attending physician.	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 1 1 YES IF YES, GIVE WAR OR DO	2 NO	If yea, s	CENDENT OF HISPA pecify Cubers, Maxic S 2 NO Speci	an, Puarlo Rica	Specify Yes or No- in, etc.)			
r aftend use as	E	15. DECEDENT'S EDI (Specify only highest grad	UCATION	16a. DECEDENT'S I	ork done durina m	ON ost of working	16b. KII	NO OF BUSINESS	/INDUSTRY	white	_
pital or	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)						
the hospital detached to	COMPL	17. FATHER'S NAME (First, Middle, Last)	4	HOT CIC	ulturis			nursery		ness	_
# 8 € €	BEC	Walter Baer	Johnston			1		a Schult	,		
retained 5 should notified	일	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural	Route Number,	City or Town, State,	Zip Code)	2105	50
ay be n page 5		Beverly J. McI				rettsvil	le Road	V			
6 may be ector, page		1 N Burlel 2 Cremation 3 Ren 4 Donation 5 Other (Specify)	noval from Stata cem	n. PLACE AND DATE One ferry, crematory or off OCLAWN ME	ner place)		DATE	20c. LOCATION			
death. Page 6 m funeral director, xaminer must		21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE -	OCF\$1		NO ADDRESS OF F		Eastor	ı, Mar	yrand	_
0 -		DYVIE, NIE	woncey -	CLE		AM FUNE					
ted within 24 hours after completely filled in by the ial, cremation, or removal event, the medical		23. PART I. Enter the diseases, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Metat	sfatic	Pros;	oda of dying, au		or reapifatory	ASTO arrest,	Approximata Interval Betwee Onset and Dec	
th certificate be executed tending physician and com I Hygiene prior to burial, or other traumatic or	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. OUE TO (OR AS A	CONSEQUENCE OF	:						
- AP -	AL	PART II. Other algolificant condition	ns contributing to death be	ut not resulting in	tha undariyin	g cause givan in		A. WAS AN AUTOPS PERFORMED?	3Y 24t	WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE	
he law requires that has been signed to Dept. of Health and 23 shows any	MEDIC									OF DEATH?	
	SICIAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES		UNCERTAI	ИП				
	SICI	EXAMINER?	HOSPITAL:		OTHER:	ne 5 Realdence					-
PHYSICIA this certif with the thed, or	РНҮ	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. IN.	URY AT		BE HOW INJURY	OCCURED		
DING PHYS After this c death with	ВУ	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆	YES 2 NO					
CTOR: A after d after d is		3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, etc. (Speci	— Al home, ferm, st	reet, factory, offic	•	28f. LOCATIO City or To	N (Street and Num own, State)	ber or Rural i	Route Number,	
TAL OR A AL DIREC 72 hours If item	COMPLETE		SICIAN: To the best of my knowle								
	S	2 MEDICAL EXAMIN	ER: On the besia of axemination	and/or investigation	, in my opinion, c	leath occured at the	lime, data and	place, and due lo) The cause(r	a) and manner as steted.	
TO THE HOSPI TO THE FUNER be filed within	BE	29b. SIGNATURE AND TITLE OF CERTIFIE	R/16 - /			29c. LICENSE NUI				(Month, Day, Year)	_
P P 8 %	2	30. NAME AND ADDRESS OF PERSON WI	COMPLETED CAUSE OF THE	ATH (ITEM 27) (James 4	Print)	0750	3/2	P .	JUNE	30,1995	47
		JOHN KEVIN	LYNCK ?	J N. Ave	C . 1	4101 B	elAir	MD.	21014	1	
		31. DATE FILED (Month, Day, Year) JUL 0 3 199	5 Java Daviso	ature and all							



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE OF MARYLAND REGISTRAR		OF HEALTH AND	MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		3. TIME OF DEATH
	CECELIA H.	JACK	SON	JULY 7	1995 YEAR	5:50 AM w
	4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 F 66	YRS. MONTHS	DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MAY 30, 1	929 8. SIRT	HPLACE (State or Foreign TV) RYLAND
DIRECTOR	98. FACILITY NAME (If not institution, give street and number) 408 HOLLYDAY STREET RESIDENCE OF DECEDENT		TOWN OR LOCATION OF DE	EATH	9c. COUNTY OF C	
EC	10e. STATE 10b. COUNTY	10c. CITY, TOWN O	OR LOCATION			10d. INSIDE CITY
	MARYLAND TALBOT 10e. STREET AND NUMBER		EASTON 101, ZIP CODE			1 X YES 2 NO
ERA	408 HOLLYDAY STREET		2160)1	10g. CITIZEN OF	WHAT COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2X IF YES, OIVE WAR OR DATES	NO	WAS DECENDENT OF HISPAN If yes, specify Cuben, Mexica 1 — YES 2 X NO Specify	n, Puerto Rican, etc.)	or No — 14, RAC	E — American Indian, k, White, etc.
0		DECEDENT'S USUAL O		16b. KIND OF SUS	I INESS/INDUSTRY	WHITE
COMPLET	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work done life. Do NOT use retired.)	during most of working			
MPI		HOMEMAKE	R	OWN	HOME	
	17. FATHER'S NAME (First, Middle, Last) JOHN HORST			ME (First, Middle, Melden .		
BE (19a, INFORMANT'S NAME (Type/Print)	19b. MAILINO ADDRESS	S (Street and Number or Rural I			
9			YDAY ST.,			1
	1 ▲ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery,	EAND DATE OF DISPOS	CEMETERY	1	CATION — City or To	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22.	NAME AND ADDRESS OF FA	CILITY	100	,
	TOHO R. MERCERO	1	EWNAM FUNE		-	MI MI
	23. PART I. Enter the diseases, or complications that caused the	dasth. Do not enter	ths mods of dying, suc	h es cerdisc or reapi	ratory arrest,	Approximata
	IMMEDIATE CAUSE (Finsi disease or condition reaulting in death) Sequentially list conditions, ff any leading to immediate	piratry	mru fficie	ny	4	Interval Between Onset and Danth
_	OUE TO (OR AS A CONS	SEQUENCE OF:	ilyen the	on in obstace	twe lung	
	m only, resuming to minimodists	EOUENCE OF):	701		dire	IN THE
S	cause. Enter UNDERLYING CAUSE (Disesse or injury					
CERTIFICATION	that initieted events resulting in death) LAST	EOUENCE OF):				
	G. PART II Other conditions conditions contribution to death had a					
CAL	PART II. Other significant conditiona contributing to death but no	creating in the un	iderlying ceuse given in	Part I. 24s. WAS AN . PERFOR		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
PHYSICIAN: MEDI	Dioleter melliten	0.00		1 🗆 YES 2	₽ 11 0	OF DEATH?
2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE	ATH YES	NO UNCERTAIN	<u> </u>		1 TYES 2 NO
CIAI		ACE OF DEATH (Check	only one)			
YSI	1 YES 2 NO 1 Inpatient 2 ER/Outpatient	3 DOA 4 Num	sing Home 5 Tesidence	8 Other (Specify)		
ву РН	27. MANNER OF DEATH 1 — Watursi 5 — Pending 2 — Accident Investigation	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRISE HOW IN	JURY OCCURED	
- 0	3 Suicide 8 Could not be determined 26e. PLACE OF INJURY — At building, etc. (Specify)	home, ferm, street, fact	ory, office	28f. LOCATION (Street a City or Town, State)	nd Number or Rural I	Route Number,
<u> </u>	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge,	death accurred at the t	Imp. data and alone, and due	4.00		
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or					i) and manner as stated.
	29b. SIGNATURE AND HTLE OF CERTIFIED		29c, LICENSE NUN		29d. DATE SIONED	
TO BE	0-0.2	rician)	2257	50	× 7/7/	95
F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT	TEM 27) (Type, Print)	11 .11	<i>r</i> /	W. T	
	CUBERT B. SANCHEZ M. D. 31. DATE FILED (Month, Day, Your) 1.02. REGISTRAN'S SIONARDINE	508 10	Hewild Ave	taston 1	no 21	601
	31. DATE FILED (Month, Day, Your) JUL 1 0 1995	Pall				
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BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

DAVID H. S 31. DATE FILED (Month, Day, Year) JUL 17 1995

30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

2

it. Pages 1, 2, 3 should TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the found after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

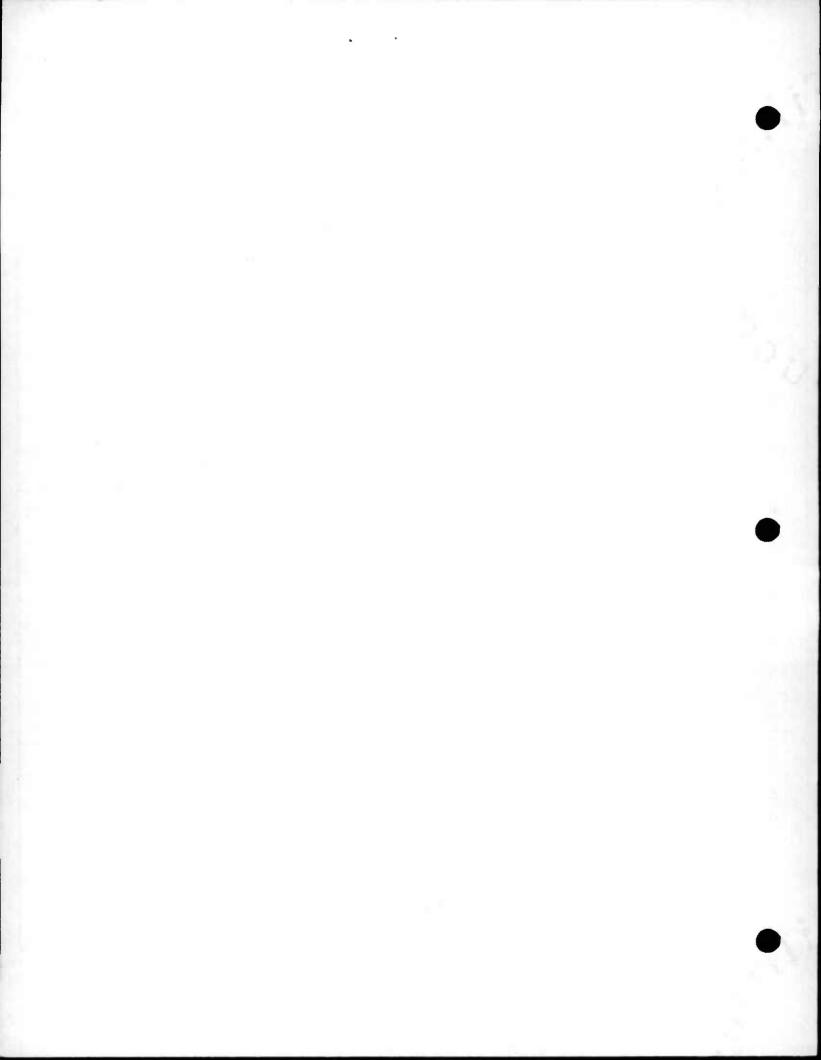
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	1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR						HYGIEN REG. NO.			Posts Not bosses w
8	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH	MY	YEAR	3. TIME OF DEATH
	EVAN	R.			Jenk:	ins				y 15	199		10:40 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER	DAYS	IF UNDER	R 24 HRS.	7. DATE OF (Month, E	BIRTH Day, Year)		8. BIRTH	PLACE (State or Foreign
	206-12-4181	X XM 2 □ F	69	YRS.	ROTTING	UAVS	HOURS	MIN.	APR.	21,	1926	PEN	NSYLVANIA
-	9e. FACILITY NAME (If not institution, give st				9b. CIT	Y, TOWN O	R LOCATIO	OH OF DE				NTY OF DE	EATH
0	MEMORIAL HOSP	ITAL		!		F	EAST	ON				TAI	BOT
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	٧		T inc. CIT	v TOWN	OR LOCATE	TON.						in a manage agent
SIR		LBOT		100.		STON							10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	прот					. ZIP COOE				T son CIT	TEN OF W	1 XYES 2 NO
R	711 ELIZABETH S	cф		•		10		2160	Λ1			USA	HAT COUNTRY?
FUNERAL	11. MARITAL STATUS		NT EVER IN U.S. AR	AMED	13	WAS DEC			NIC ORIGIN?	Carelly Va			A Indian
	1 Never Married 2 Merried	FORCES? 1	YES 2 N	NO		If yes, spe-	ecify Cubar	nn, Mexicai	an, Puerto Rice		or No-	Black	— American Indian, White, atc.
BY	3 Wildowed 4 Divorced	NAVY	WW I	I		1 YES	2X NO	Specify	y:		1	Specif	WHITE
COMPLETED	15. DECEOENT'S EDUC (Specify only highest grade	CATIOH	18e. OF	ECEOENT'S	USUAL C	CCUPATIO)N		16b. K	IHO OF BU	SIHESS/IND	USTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5	life	Bive kind of w Do NOT us	se retired.)	dufing mos	t of working	g					
MP	7		· ·	TEST	CU'	TTEF	.t			STI	EEL 1	MILI	i
00	17. FATHER'S HAME (First, Middle, Lest)						18. MOTI	HER'S HA	AME (First, Mide	dle, Maiden	Surname)		
BE	NORMAN M. JENI	KINS					1	MAR	IE HA	RLEY	I		
10 B	19e. IHFORMAHT'S HAME (Type/Print)		197	b. MAILING	ADORES	S (Street or	nd Number	or Rural I	Route Number,	City or Tow	n, State, Zip	Code)	
-	LUCRETIA R. JEN	NKINS		711	ELI	ZABF	HT	ST.	, EAS	STON .	, MD	216	501
	20e. METHOD OF DISPOSITION Burlel 2 Cremation 3 Remo	oval from Stata	20b. PLACE A cemetery creat WHITE	AHDDATEO	OF DISPOS	SITION (Nan	me of		7-17	20c. LO	CATION — C	City or Tov	wn, State
	21. SIGNATURE OF FUHERAL SERVICE LIC	EHSEE	8		22.	. HAME AHO	O ADDRES	SS OF FAC	CILITY				
	+ B. Keith	Phys		FSF	1	200	S. I	HARI	ERAL RISON	ST.	. , EZ	ASTO	ON, MD
	23. PART I. Enter the diseases, or coshock, or heart failure. I	complications the List only one cer	it caused tha de- use on each line	ath. Do n	ot anter	tha mod	le of dyl	ng, such	h as cardia	c or respi	ratory arr	est,	Approximata Interval Between
	IMMEDIATE CAUSE (Final	11.1.	1 +1	ni.	-	+		3-					Onset and Death
	disesse or condition resulting in death)	· Metas	, rulec	mi	15/2	le	U	an	Q~				OMUS.
		DUE TO	OR AS A COHSEC	DUENCE OF	·):								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSEC	OUENCE OF	F):								
S	csuse. Enter UNDERLYING CAUSE (Disesse or Injury	c											
FI	that initisted events resulting in death) LAST	OUE TO	OR AS A COHSEO	DUENCE OF):								
ER	resulting in death) CAST	d											
- H	PART ii. Other significant conditions	s contributing to	deeth but not r	politing	In the u	nderlying	Cause (ni nevin	Dart I 2	fa. WAS AN	ALITODRY	24b	WERE ALTOROV SMITHLES
MEDICAL		-			// w/o a	derlying	Canen a			PERFOR	RMED?	1 1 1 1	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DE CAUSE
ED									— I 1	YES 2	THO		OF DEATH?
	DID TOP ACCO LICE CONTE	OUDLITE TO CA	LICE OF DEA				1.000						1 TES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTR	(IBUIL IO CA					UNC	ERTAIN	<u>1 □ </u>				
S	EXAMIHER?	HOSPITAL:		CE OF OEAT	OTHER	R:							
₹ I	1 YES 2 NO 27. MANHEB OF DEATH		ER/Outpatient 3		4 🗆 Nun	rsing Home	_	eldence	8 Other (S				
	1 Natural 5 Pending	28e. DATE OF (Month, Da		28b. TIME	E OF JURY	28c. INJU WOR	RK?	_ == 1	28d. OEŞCR	IBE HOW IF	IJURY OCC	URED	
B	2 Accident Investigation	200 PLACE (or Manny At he	1000			'ES 2 🗌	NO					
COMPLETED	3 Suicide 8 Could not be determined	building,	OF INJURY — At hor, etc. (Specify)	ne, lerin, a	ireet, tecu	ory, office			281. LOCATION City or 7	OH (Street a Town, State)	nd Number	or Rural Ro	oute Number,
7	29a. CERTIFIER (Check only	CIAH: To the best of	my knowledge, de	ath occum	ed at the	time, date	and place	and due	to the cause	(a) and mar	Tor on stat	- d	
Σ	one) 2 MEOICAL EXAMINER												and menner on stated.
		-						_			,	B	march treatment on assessment
BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER							ÉNDÉ-VON					Month, Day, Year)

SMITH, M.D., 509, IDLEWILD AVENUE, EASTON,

29d. DATE SIGHED (Month, Day, Year) 95

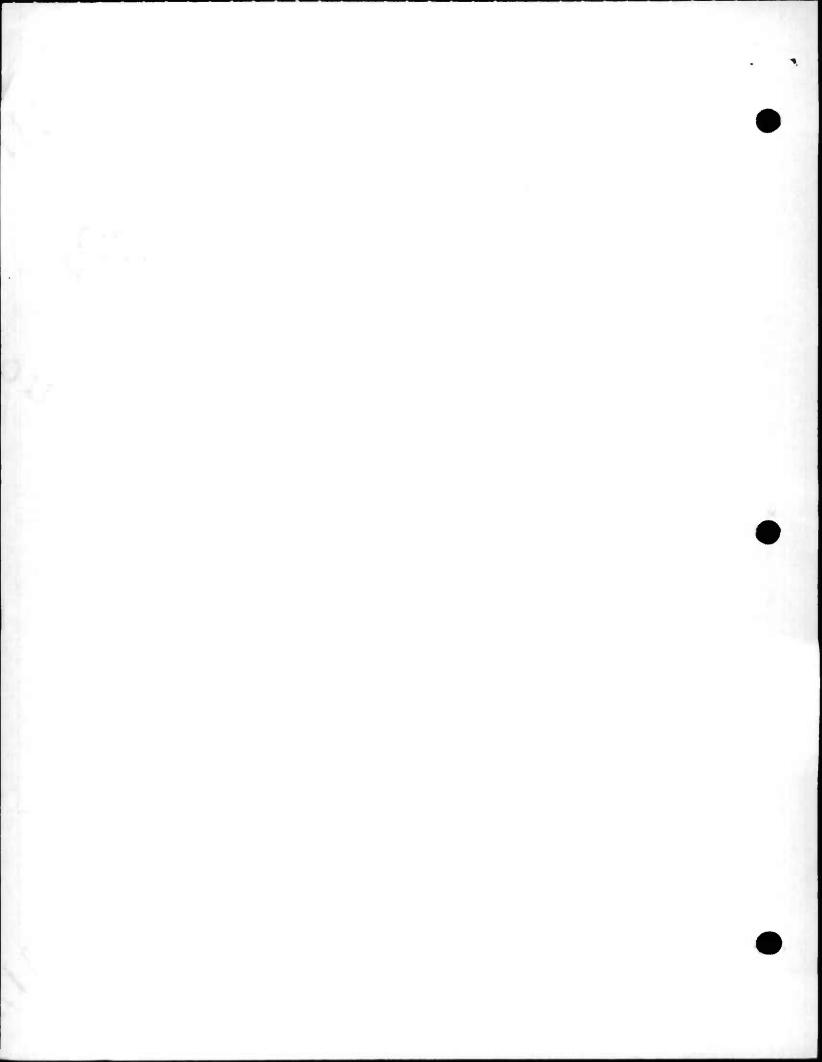
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n certificate be executed within 24 hours after death. Page 6 may be retain	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certifi	DIRE
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	REGISTRAR								
	1. DECEDENT'S NAME (First, Middle, Las	00	CER	TIFICAT	E OF	DEATH	REG.		
	Doro	thu Torda	~				July 15	DAY	YEAR 3. TIME OF DEATH
		thy Jorda 5. SEX 6.		thday) IF UND	DER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BURE		
	218-01-0643	1 🗆 M 2 📉 F	89	YRS. MONTHS		HOURS MIN,	April 7	,1906	6. BIRTHPLACE (State or Foreign Country) Italy
Œ	9a. FACILITY NAME (If not institution, given 2111 Spencer				ty, town o inksl	DR LOCATION OF DE	EATH		TY OF DEATH
1 2	RESIDENCE OF DECEDENT					our 9			
DIRECTOR	10a. STATE 10b. COUN		1	C. CITY, TOWN					10d. INSIDE CITY LIMITS?
	Maryland 100. STREET AND NUMBER	Carroll		Finks					1 TES 2 NO
FUNERAL	2111 Spencer	Lane			101	21048			EN OF WHAT COUNTRY?
N	11. MARITAL STATUS	12. WAS DECEDENT E	VER IN U.S. ARMED) 13	3. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify		14. RACE — American Indian
BY F	1 Never Married 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 IF YES, GIVE WAR	YES 2 NO OR DATES		If yea, sp	ecify Cuban, Maxica 2 NO Specify	n, Puarto Rican, atc.)		Black, White, atc. Specify: White
ED E	15. DECEDENT'S ED	DUCATION	16+ DECED	ENT'S USUAL	OCCUBATIO	201	December 200		
ш	(Specify only highest gra-	de completed) College (1-4 or 5+)	(G/ve A	ind of work done NOT use retired.	e durina mo		166. KIND OF	BUSINESS/INDL	JSTRY
COMPL	6			Hous	ewif	e	Hom	nemake	r
CO	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Middle, Maid	len Sumame)	***
BE		e Testudi					Busterna	-	
5	194. INFORMANT'S NAME (Type/Print) Lee G. Jordan	1					Poute Number, City or		Md. 21048
	20s. METHOD OF DISPOSITION		20b. PLACE AND						Ity or Town, State
	1 Burlai 2 Cremation 3 Ra 4 Donation 5 Other (Specify)	moval from Stata	Garden	ory or other plece	aith	1	7/18/12	altimo	ore Md
	21. SIGNATURE OF FUNERAL SERVICE I	LICENSEE	. 4	22	2. NAME AN	D ADDRESS OF FA	CILITY FIT. E'TI C'	ਾਜ ਕਾਜ	JNERAL HOME
	Nany V	Fleth	1	2	254 1	EAST MA	TN ST.W	ESTMIN	ISTER, MD.
	ehock, or beart fellure iMMEDIATE CAUSE (Finel disease or condition	s. List only one cause	on eech line.		er the mo	de of dying, suci	n es cardiec or re		at, Approximate Interval Betw
RTIFICATION	IMMEDIATE CAUSE (Finel	a. PEMENDUE TO (OR	on eech line.	PLZ	er the mo	de of dying, suci	n es cardiec or re		
CERTIFICATION	iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	a. PEMENDUE TO (OR DUE TO (OR DUE TO (OR	AS A CONSEQUENT AS A CONSEQUEN	OLZ HICE OF):	er the mod	de of dying, such	n es cardiec or re		Approximate Interval Betwo
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E COMPLETED BY PHYSICIAN: MEDICAL	iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significent condition INFECTED DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation investigation distortined 29a. CERTIFIER Check only	a. DEMENDUE TO (OR b. DUE TO (OR c. DUE TO (OR d. DUE TO CAUS TRIBUTE TO CAUS HOSPITAL: 1 Inpetlant 2 ER 28e. DATE OF INJ (Month, Day, Y 28e. PLACE OF IN building, atc.	AS A CONSEQUENT AS A CONSEQUEN	VES DEATH (Check DOA OTHE DOA OTHER	NO Landerlying NO Landerlying NO Landerlying k only one) ER: uraing Home 28c. INJU UVO 1 Landerlying time, dete	UNCERTAIN S PRESIdence URY AT RK? ES 2 \(\) NO and pleca, and due	Part i. 24a. WAS PERF 1 YES 6 Other (Specify) 28d. DESCRIBE HOW City or Yown, State to the cause(a) end in time, date end place,	AN AUTOPSY ORMED? 2 — MO W INJURY OCCU et and Number or tele)	24b. WERE AUTOPSY FINDIN AMILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO
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E COMPLETED BY PHYSICIAN: MEDICAL	iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST PART II. Other significent conditions. INFECTED DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINERY 2 MEDICAL EXAMINERY 1 CERTIFING PHY:	a. DEMENDUE TO (OR b. DUE TO (OR c. DUE TO (OR d. SPECED L TRIBUTE TO CAUS HOSPITAL: 1 Inpetiant 2 ER 25e. DATE OF INJ (Month, Day, Ye) 25a. PLACE OF INJ building, stc.	AS A CONSEQUER AS A CONSEQUER	YES TO STATE OF INJURY MELTING IN IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MELTING IN INTURY MET INTURY ME	NO La k only one) R: underlying R: uning Home 28c. INJI WOI 1 Y ctory, office	UNCERTAIN 5 D Rasidence URY AT RES 2 NO and place, and due eath occured at the 29c. LICENSE NUM 1 6	Part i. 24a. WAS PERF 1 YES 1 Other (Specify) 28d. DESCRIBE HOW City or Yown, Size to the cause(s) end in time, date end place, BER	AN AUTOPSY ORMED? 2 — MO V INJURY OCCU et and Number or te) Part of the state of	24b. WERE AUTOPSY FINDIN AMILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO



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DIVISION	
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	`	1 - FOR STATE REGISTRAR	STATE OF MARY	AND / DEPAI CERTIF	RTMENT OF	HEALTH AND	MENTAL HYGIE							
		1. DECEDENT'S NAME (First, Middle, Lest) DANELL			JOHNSON		2. DATE OF DEATH		YEAR	. TIME OF DEATH				
		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. last birthday)		R IF UNDER 24 HRS.	JULY 9,	1995		03:01A ACE (State or Foreign				
-		213-86-9137	1 📉 M 2 🗆 F	32 YRS.	MONTHS DAY		July 29,		Country)					
should		9e. FACILITY NAME (If not institution, give str	reet end number)		9b. CITY, TOW	N OR LOCATION OF E		9c. COUNT		land TN				
2, 3 should	OR	THE JOHNS HOP	KINS HOSPITA	AL.	BAI	TIMORE C	ITY							
es 1	DIRECTO	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c, Cl	TY, TOWN OR LO	CATION			Ti.	Od. INSIDE CITY				
t. Pag	DIA	Maryland Calve	ert		Hunting	ztown			1.0	LIMITS?				
E-86	AL	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZE		AT COUNTRY?				
an. ransit	FUNERAL	280 Wilson Rd.				20639			US	A				
215-0020 attending physician. use as the burial-transit permit. Pages 1,	B	11. MARITAL STATUS 1 X Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES	2 X NO	If yes,	epecify Cuben, Mexic (ES 2 X NO Speci	ANIC ORIGIN? (Specify Youn, Puerto Rican, etc.) Hy:	ee or No— 14	Black,	- American Indian, White, etc. Black				
	9	15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	16e. DECEDENT'S	S USUAL OCCUPA work done during	ATION most of working	16b. KIND OF B	USINESS/INDUS	TRY					
d for u	LET	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Ilfa. Do NOT u	ise retired.)	most or norming								
AND 2 the hospital detached fo	COMPL	12 17. FATHER'S NAME (First, Middle, Last)		Assen	bler			struct:	ion					
A A A A A A A A A A A A A A A A A A A	E C	Charles Walter	Johnson		17	Gerald:	AME (First, Middle, Meide ine	n Sumame) Lon	g.					
MARYLAND 21 retained by the hospital or 5 should be detached for u notified at once.	<u> </u>	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	G ADDRESS (Street		Route Number, City or To							
E, M y be ref sage 5 s	인	Geraldine Johnson		280 Wi	lson Ro	d. Hunti	ngtown, MD	20639						
ORE ector, pag must b		20a METHOD OF DISPOSITION 1												
Page (4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE		tuxent (and address of F								
BALTIMORE, er death. Page 6 may be the funeral director, page val. I examiner must be		> Monde a	. Sevell	•			Sewell							
		23. PART i. Enter the diseases, or co					ach Rd. Pr							
My within 24 hours after ompletely filled in by the i. cremation. or remova event, the medical		iMMEDIATE CAUSE (Fine)	RESPIR	ATURY	ARRE			piratory erree	¢,	Approximeta interval Between Onset and Death				
X 68 x execute in and co to buria	TION	Sequentially list conditions, if any, leading to immediate	quentielly list conditions, The Pulmonage Embours, MASSIVE											
certificat nding phy Hygiene p	ERTIFICATION	cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	DUE TO (OR AS	A CONSEQUENCE O	IF):									
he death the atter Mental	O	PART II Other clautiles a condition								1				
that the the the the the the the the the th	MEDICAL	PART II. Other eignificent conditions	contributing to death t	out not reaulting	in the underly	ing ceuse given in		RMED?	A	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?				
RECO requires been sign t. of Healt shows		DID TOBACCO USE CONTR	IBLITE TO CAUSE O	DE DEATH Y	ES [] NO	UNCERTAI	N D		1	YES 2 NO				
has beg	SICIAN	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEA			МП							
VIIAN: The crifficate the State or Item	SIC		HOSPITAL: 1 Vinpatient 2 ER/Out	patient 3 DOA	OTHER: 4 Nursing N	ome 5 🗆 Residence	8 Other (Specify)							
HYSICI his cer with th	PHY	27. MANNER OF DEATN 1 Natural 5 Pending	28a, DATE OF INJURY (Month, Day, Year)	28b. TIN	IE OF 28c. 1	NJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCUP	RED					
ON OP OP OP OP OP OP OP OP OP OP OP OP OP	BY	2 Accident Investigation				YES 2 NO								
OLVISION OF VI OR ATTENDING PHYSICIAN: DIRECTOR: After this certifica hours after death with the Siz item 28 is marked, or It	ETED	3 Suicide 6 Could not be determined	26e. PLACE OF INJURY building, etc. (Spec	сяу)			281. LOCATION (Street City or Town, State))	Rural Rou —	le Number,				
4 4 Z	COMPL	29a. CERTIFIER (Check only one) 1 Le CERTIFYING PHYSIC MEDICAL EXAMINER	IAN: To the best of my know : On the basis of examination	rledge, death occurr n and/or investigation	ed at the time, do	ate and place, and due , death occured at the	n to the cause(a) and ma o time, date and pieca, a	nner se stated,	euse(s) e	nd menner se atated.				
THE HO filed wit	BEO	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER	29d. DATE S	IGNED (M	onth, Day, Year)				
TO THE HOSPIT TO THE FUNER De filed within 7 IMPORTANT:	0	Shull Bot In	1)			NSIRS		> c	7/	09/1995				
3		30. NAME AND ADDRESS OF PERSON WHO JOHN R. DOTY ME	DEPTOFS	urbery,	JOHNS	HOPKINS 1	408 PIMZ, 5	BARAM	UR+	NO				
		JUL 1 3 1995	32 REGISTRAR'S SIGN	n-Rardall										

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31. DATE FILED (Month, Day, Year) JUL 2 1 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

Pages 1, 2, 3 should

permit.

DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in be filed within 72 hours after death with the State Oept. of Realth and Mental Hygiene prior to burial, cremation, or re	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the med
	L OR	Hour	item
	SPITA	JERAI Jin 72	=======================================
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH July 19, **EMERSON** YEAR E. JARRELL 1995 0.42 AM 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTN (Month, Day, Year) March 5, 1995 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign DAYS HOURS 233-30-7692 1 X M 2 | F MONTHS 73 West Virginia 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 10b. COUNTY 10e STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Crisfield Maryland Somerset 1 X YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 415 Myrtle St. 21817 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Specify: White 16a. DECEDENT'S USUAL OCCUPATION BE COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Grade 8 Maintenance Supervisor Steel Drum Mfg. - - -17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Jacob Jarrell Pink Webb 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Shirley Back (daughter) 10287 Astoria Road - Germantown, Ohio 45327 20s. METNOD OF DISPOSITION

V. Buriel 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Sunnyridge Memorial Park 7/22/95 Crisfield, MD 21. SIGNATURE OF RUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Bradshaw & Sons Funeral Home Kaluar Buch keun Robert H. Bradshaw 306 W. Main St. - Crisfield, MD 21817 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Cardiogenic shock

DUE TO (OR AS A CONSEQUENCE OF):

Acute Myp. Infanctim. IMMEDIATE CAUSE (Final Onset and Daath disease or condition resulting in death) CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, laading to immediate artem disease. Coronary cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSECU that initiated events reaulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO MEDICAL 24a. WAS AN AUTOPSY PERFORMED? COMPLETION DF CAUSE 1 YES 2 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be determined COMPLETED 4 Nomicide 29e. CERTIFIER 1 DEERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee atteted. EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner as stated, 296. SIGNATURE AND THE OF CERTIFIED 29c. LICENSE NUMBER 25034 Toela 29d. DATE SIGNED (Month, Day, Year) BE

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share Drive SALISBURY M.D.

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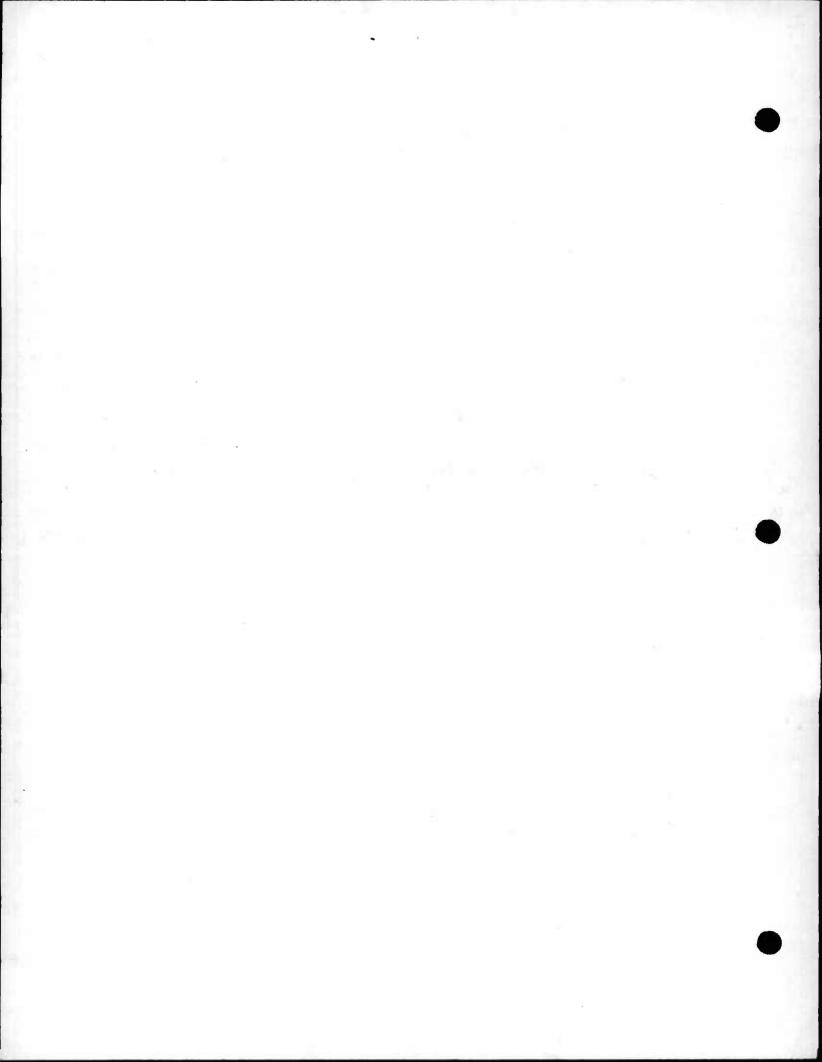
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. & BALTIMORE, MARYLAND 21215-0020

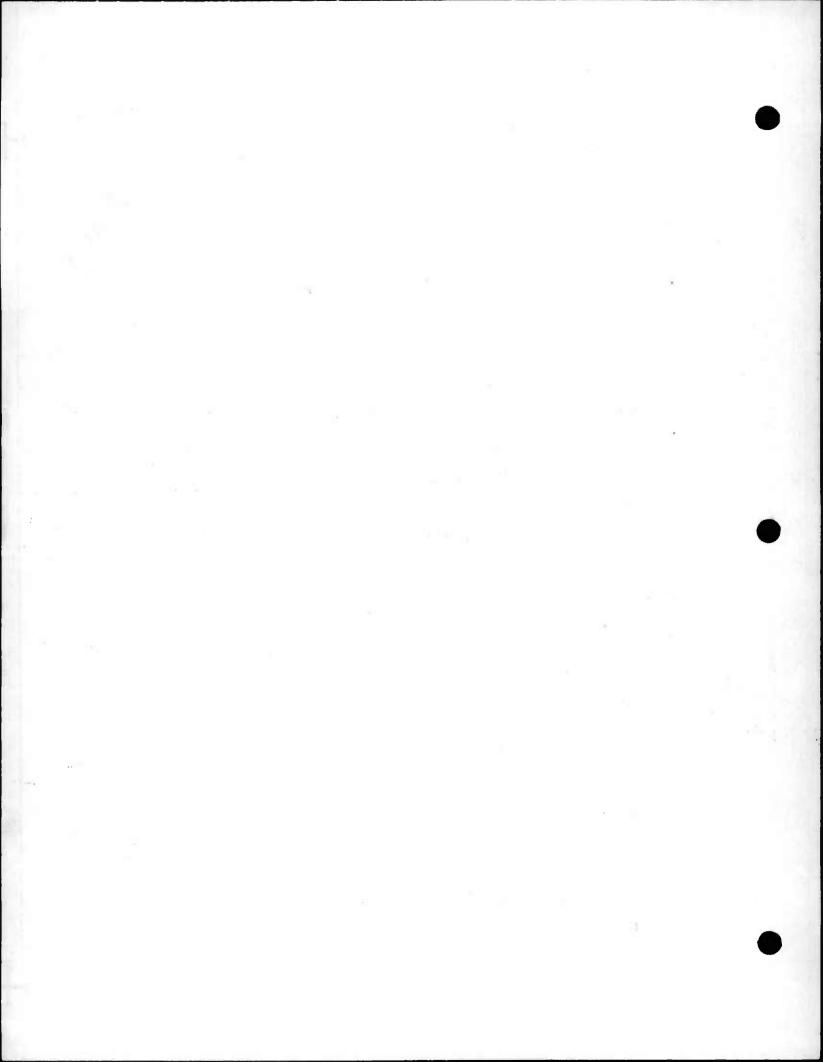
DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	ENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENI REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH			
	PATSY	ANN	IOHNSON		JULY 14.	1995	11 31P M			
			MO	UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	6. BIRT	HPLACE (State or Foreign			
	3.0 00 /31/	578-60-7517 1 M 2 X 49 YRS. WORTHS DATS HOURS MIN. O. 98. FACILITY NAME (if not institution, give street and number) 99b. CITY, TOWN OR LOCATION OF DEATH								
DIRECTOR	PRINCE GEORGE GENER			CHEVERLY	JEATH	9c. COUNTY OF PRINCE				
REC	10a. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCATION			10d. INSIDE CITY			
	MARYLAND PRINCE	GEORGE	CAPIT	OL HEIGHTS			LIMITS?			
FUNERAL	10e. STREET AND NUMBER			10f. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?			
N.	#6710 DRYLOG STREET	L 12. WAS DECEDENT EVER IN	U.S. ARMED	20743 13. WAS DECENDENT OF HISPA	NIC ODICINA (Secolar V.	UNITED				
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 VNO	It yes, specify Cuban, Maxic	an, Puarto Rican, etc.)	or No— 14. RAC Blac Spe	E — American Indian, ck, White, atc. city: BLACK			
8	15. DECEDENT'S EDUCAT (Specify only highest grade co.	TION (mpleted)	16a. DECEDENT'S USL	AL OCCUPATION	16b. KIND OF BUS	INESS/INDUSTRY	BEFOR			
COMPLETED	Elementary/Secondary (0-12) 12TH GRADE	Callege (1-4 or 5+)		done during most of working lired.)						
OMI	17. FATHER'S NAME (First, Middle, Last)		SECURITY		GOVERN AME (First, Middle, Meiden 5					
BE C	JOSEPH GOODWIN									
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADI	DRESS (Street and Number or Rural	GRAHAM GOO Route Number, City or Town					
	CAREN JOHNSON		#6710 DE	RYLOG STREET,	CAPITOL HEI	GHTS, M	20743			
	20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Ramova 4 □ Donation 5 □ Other (Specify)	of from State cem	PLACE AND DATE OF D	SPOSITION (Neme of	DATE 20c. LOC	CATION — City or 1	own, Stata			
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE /	1	MONY MEMORIAL 22. NAME AND ADDRESS OF F	ACILITY		SVILLE, MD.			
	LYDIA C. THORNT	ON JOHNSON		THORNTON FUNE #3439 LIVINGS	RAL HOME, P		AD MD 20640			
	23. PART I. Entar tha diseasea, Dr CDr ahock, Dr haart fallure. Lis	mplications that caused	tha death. Do not a	inter tha moda of dying, su	ch aa cardlac or reapir	ratory arrest,	Approximate			
	IMMEDIATE CAUSE (Final	AA - 3 /A 16	The state of the s	BOEN	C	- 0	intarval Between Onsat and Death			
	disease or condition resulting in death)	PUE TO COD AS A	CONSEQUENCE OF:	BREAST	RING	2 R	2 years			
_		DOE TO (OH AS A	CONSEQUENCE OF):				' 1			
0	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):							
15	CAUSE (Disease or injury	DUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION	that initiated events reaulting in death) LAST	DOE TO (ON AS A	CONSCOUENCE OF):							
	PART II. Other algnificant conditions of	contributing to death be	it ont resulting in th	s underlying cause gluon is	Part I. 24s, WAS AN A	urroney Lev				
CAL	HYPst	115,50	SHOC	1	PERFORM	WED?	AWAILABLE PRIOR TO COMPLETION OF CAUSE			
	RENAI		CRICIE		1 YES 2	⊠ NO	OF DEATH? 1 YES 2 NO			
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF	DEATH YES	NO D UNCERTAI	N 🗆		1 163 2 100			
CA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:	6. PLACE OF DEATH (C	heck only one)						
IXS		⊠Inpatient 2 ☐ ER/Outpo	itlant 3 DOA 4 D	Nursing Homa 5 - Residence						
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME OF INJURY	28c, INJURY AT WORK? M 1 YES 2 NO	28d. DEŞCRIBE HOW IN	JURY OCCURED				
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide daterminad	26a. PLACE OF INJURY building, atc. (Speci	— At home, farm, atras	, Inctory, office	281. LOCATION (Street an City or Town, Stete)	nd Number or Rural	Route Number,			
9	29a. CERTIFIER									
COMPLET				the time, date and place, and dur my opinion, death occured at the			and manner as stated			
	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU		29d. DATE SIGNED	THE THE ASSESSMENT			
O BE	M.M	05/0cm	M.C	DZ4	061	▶ 7	719+			
2	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Princ		\					
	31. DATE FILED (Month, Day, Year)	32. DEGISTRAR'S SIGNA	TURES							
N	0011 0 1000	1/1								



FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE
DECEDENT'S NAME (First Middle Last)		

		REGISTRAR		CERTIF	ICATE O	F DEATH	RE	EG. NO.				
_		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D	EATH	1	3. TIME OF DEATH		
		Glenn Fllis Jol	laint ain				JULY	17 199	YEAR	1940 M		
		4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR	R IF UNDER 24 HRS.	7. DATE OF BI			LACE (State or Foreign		
		219-46-1043	104006	No.	MONTHS DAYS		(Month, Day,	Year)	Country)	LACE (State or Poreign		
should		9a. FACILITY NAME (If not institution, give s.			AL OUTY TOW		Sept.	22, 1947		yland		
3 sho	œ			1	96. CITY, TOWN	N OR LOCATION OF O	EATH	9c. COUNT	Y OF DEA	ίτн		
2,3	DIRECTOR	Washington Count	<u>ty Hospital</u>		На	gerstown			shine	oton		
	E E	10a. STATE 10b. COUNTY		10c CIT	Y, TOWN OR LOC	D			-			
Pag	E	, C142 (110)								IOd. INSIDE CITY LIMITS?		
permit. Pages		10e. STREET AND NUMBER	hington		<u>Smiths be</u>					YES 2 NO		
	A.	TOTAL STREET STREET				101. ZIP CODE		10g. CITIZE	EN OF WH	IAT COUNTRY?		
an. ransi	y	11824 Crystal F				21783		u.s	S.A_			
215-0020 attending physician. se as the burlal-transit	FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS OECEDENT EVER IN FORCES? 1 YES	N U.S. ARMED	13. WAS D	ECENDENT OF HISPAI specify Cuban, Mexica	NIC ORIGIN? (Sp	ecify Yes or No- 1	4. RACE -	- American Indien, White, atc.		
the bu	ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			ES 2 NO Specif		etc.j	Specify:			
as th										White		
3	ETED.	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S (Give kind of v	WORL OCCUPATION OF THE PROPERTY OF THE PROPERT	TION most of working	16b, KIND	OF BUSINESS/INDU	STRY			
	<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	lite. Do NOT us	te retired.)							
ched	A P	Graduated		Cabnet	Maker		S	tatton Fu	ודגדוו	170 C O		
the hospital or detached for u	COMPL	17. FATHER'S NAME (First, Middle, Last)						Maiden Surname)	1	717		
1 5 6 K	BE (Paul William Joh	inson S.R.			Manan	not Ama	nda Leath	- 0 4 ma			
MARYLAND 2- retained by the hospital of 5 should be detached for notified at once.		19a. INFORMANT'S NAME (Type/Print)	777	19b. MAILING	ADDRESS (Stree	et and Number or Rural	Route Number, Ch	tv or Town. State, Zip C	IVЛIIII Pode)	И		
(A) (I)	2	A. Ray Johnson										
RE, may be or, page		20a, METHOD OF DISPOSITION	201	PLACE ANODATE O		tal Falls	DATE	MATHS DUTY OF	Md_	21783		
		1 K Burist 2 ☐ Cremation 3 ☐ Remo		netery, crematory or of	ther place)					i, State		
Page at direc		21. SIGNATURE OF FUNERAL SERVICELLIC	eved /			ithsburg	7/20	Smithsb	wrg			
F a F		M. 111	71/		22. NAME	ANO ADDRESS OF FA	Da	vis F.H.				
SALT death. e funera al. examir		7///0/07////	Ckelver	_	1 7	TOENE REAL	11 A	0				
rs after of removal.		23. PART I. Enter the diseases, or o	complications that causer	the death. Do r	of enter the r	12525 Brac	IDWLU A	ve. Smian	<u>sbur</u>			
		spock, or neart tellure.	List only one cause on as	ach lina.	Ol amor me n	noda or dynig, auc	n an cardine o	or reapiratory arres	st,	Approximata Interval Batween		
	H	IMMEDIATE CAUSE (Final disease or condition	Pon	A.1	12. 11.	11.7 - Varis	1)	Later 1		Onaat and Death		
or within 24 in completely fille		resulting in death)	CONCIDINA C	soldy or	in las	VINKILLA.	7-60M	, 000		2 8cm1		
68760 ecuted wit nd comple buriat, cre atic even			OUE TO OR AS A	CONSEQUENCE OF	7):	1	/					
	Z		· Morre	7				/				
× 10 =	RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	ን:			t.				
	3	cause. Enter UNDERLYING CAUSE (Disease or Injury	e.									
O. B ertificat ing phy rigione p		that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	1 :							
· 등 등로 늘		resulting in death) LAST										
DS, F ne death the atter Mental	E I		*									
	4	PART II. Other significant condition	a contributing to daeth be	ut not reaulting i	n tha underly	ing cause given in	Part I. 24a.	WAS AN AUTOPSY PERFORMEO?		ERE AUTOPSY FINDINGS		
amy amy	EDICAL							YES 2 NO	CC	OMPLETION OF CAUSE		
T 3 0 T 2 1							_ ' '	120 2 [2] 110		F DEATH?		
C = 80.2	Σ.	DID TOBACCO USE CONTR	RIBLITE TO CALISE O	E DEATH YE	SUND	UNCERTAIN			1 '	YES 2 NO		
2 e s e	NA I	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF OEAT			4 L					
	PHYSICIAN:	EXAMINER?	HOSPITAL:		OTHER:							
F VIT. SICIAN: The certificate to the State I, or item	YS	1 YES 2 NO	1 inpetiant 2 ER/Outpu		4 - Nursing Ho	ome 5 - Rasidence	6 Other (Spec	offy)				
PHYSIC this ce with th	F	27. MANNER OF CEATH 1 Autural 5 Pending	(Month, Day, Year)	26b. TIME	URY V	NJURY AT WORK?	26d. OEŞCRIBE	E HOW INJURY OCCU	REO			
ON OF ON OF OTHER CONTROL OF THE CON	B	1 Matural 5 Pending 2 Accident Investigation			M 1	YES 2 NO						
OIVISION OR ATTENDING DIRECTOR: After hours after death		3 Suicide 6 Could not be	28a. PLACE OF INJURY building, etc. (Speci	- At home, farm, a	street, factory, off	fice		(Street and Number or	Rural Rou	te Number,		
ATTEN CTOR: s after 28 1	ш	4 Homicide determined		39)			City or Tow	n, State)				
S S S S S S S S S S S S S S S S S S S		290. CERTIFIER 1 CERTIFYING PHYSIC	CIAM: To the heat of my know.									
로 보고 도	₹		CIAN: To the best of my knowle									
HOSPITAL FUNERAL WITHIN 72 I	COMPL		R: On the beale of examination	end/or investigation	n, in my opinion,	, death occured at the	time, date and p	laca, and due to tha	ceuse(a) a	nd menner as stated.		
TO THE HOSPI TO THE FUNER Be filed within	шШ	296. SIGNATURE AND TITLE OF CERTIFIES	1/		29c. LICENSE NUMBER 29d. DATE SIGNED (Month)					fonth Day, Year)		
TO THE TO THE IN	<u>a</u>	no beneficial mo			1 West > 718-15					27		
	2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DEA	ATH (ITEM 27) /1/20.	Prig()	de d	. 1.	1				
		EX-LANDIZAM	N 362 Drd	on Olei	alky	XAHIIII	MM (118)	21141	1	146		
	- 1	31. DATE FILED (Month, Day, Year)	32 REGISTRAN SOIGN	TURE		Myell	0, 4	7.710				
		JUL 1 9 1995 /	the somewhat have	all		/						



FOR STATE DEGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	CENTIFICATE OF DEATH REG. NO.														
	1. DECEDENT'S NAME (First, Middle		- v mamil								2. DATE O	D/	MY	YEAR	3. TIME OF DEATH
	ANN		ZABETH			LING	_				JUL		7 1	995	8:10 Am
- 0	4. SOCIAL SECURITY NUMBER		SEX			t birthday)	IF UNDER	DAYS	IF UNDE	ER 24 HRS.	7. DATE O (Month,	F BIRTH Day, Year)		s. BIRTH Countr	PLACE (State or Foreign y)
	236-58-0905		□ M 2 F	88	3	YRS.						22, 1			W.VA.
~	9e. FACILITY NAME (If not institution		and number)				1			TION OF DE	EATH			JNTY OF D	
DIRECTOR	MEMORIAL HOSPI						CU	MBEF	(LAN	D			AL	LEGA	NY
EC		COUNTY				10c. CIT	ry, town (OR LOCA	TION						10d. INSIDE CITY
E I	W.VA. M	INERA	AL		WILEY FORD									LIMITS?	
	10e. STREET AND NUMBER						101. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	CITY VIEW AVE.								26	767				S.A.	
5	11. MARITAL STATUS		. WAS DECEDENT	EVER IN	U.S.ARI	MED	13.	WAS DEC	ENDENT	OF HISPAN	VIC ORIGIN?	(Specify Yes		14. RACE	— American Indian,
BY F	1 Never Married 2 Merried 3 Wildowed 4 Divorced	d	FORCES? 1			0		If yes, sp 1 YES	2 NO	en, Mexica Specify	in, Puerto Ri y:	can, etc.)			White, etc.
	3 M whomed a Divorced														WHITE
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) 16c. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) 16b. NOT use retired.													227227	
١٣	Elementary/Secondary (0-12) College (1-4 or 5+) Beloweritary/Secondary (0-12) College (1-4 or 5+) COOK—MINERAL CO SC HOUSE KEEPER / COOK HOUSE KEEPER													SCHOOLS.	
NA I	8 HOUSE KEEPER / COOK HOUSE KEEPER 17. FATHER'S NAME (First, Middle, Last)												ŁK		
ö	JAMES HENRY NEWLEN 18. MOTHER'S NAME (First, Middle, Lest) JAMES HENRY NEWLEN SARAH ANN FLEMING												7		
BE	10. INFORMANT'S NAME (Knockhiet)														
2	MRS SHELBY GRO			W.V		n, State, Zi; 26767									
	20a. HETHOD OF DISPOSITION 1. Burlal 2 Cremation 3	_		20b.						LION		_			- Penta
	4 Donation 5 Other (Specify	(y)		State 200. PLACE AND DATE OF DISPOSITION (Name of Sunsering Committe											
	21. SIGNATURE OF FUNERAL SERV	ICE LICENS	F _ 1	22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME											
	- Wale à	₹. <u>I</u> I	lerutt				40	4 DE	ECAT	UR ST	CREET	CUMBE	ERLAN		RYLAND
	23. PART I. Enter the disease shock, or heart fa	s, or com	plications that	caused	tha der	eth. Do r	not anter	the mo	da of dy	ying, suct	h as cardi	ac or respi	iratory ar	reat,	Approximeta
	IMMEDIATE CAUSE (Final	Mule. Lie.	Oliny Dire Case	10 Dir ve	CII III re.										Intarval Between Onset and Death
	disease or condition reaulting in death)	,A	cute My	ocar	dia	1 In	farc	tion	. St	ibend	ocard	lia]			2 Days
			DUE TO (OR AS A	CONSEC	DUENCE OF	F):		<u> </u>		000_	2.4.			2 1000
N	Sequentially list conditions,	b													
E I	If any, leading to immediate cause. Enter UNDERLYING		DUE TO (OR AS A	CONSEQ	OUENCE OF	F):								
S	CAUSE (Disease or injury	c	DUE TO (OR AS A	CONSEQ	DUENCE OF									
Ē	that initiated events resulting in death) LAST		DOE 10 !	On Mo A	CONSEG	DENCE OF	7):								
CE		d													1
EDICAL CERTIFICATION	PART II. Other significant con					asuiting i	in the ur	nderiying	g cause	given in	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DIC	Severe Left V	Ventr	icle Fa	<u>ilur</u>	e							1 TES 2			COMPLETION OF CAUSE DF DEATH?
ME													***		1 TYES 2 TO
	DID TOBACCO USE CO	ONTRIB	UTE TO CAI	JSE OF	DEAT	TH YE	es 🗆 :	NO 🗷	UN	CERTAIN	4 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDI- EXAMINER?		Control .	2	6. PLACE	E OF DEAT	TH (Check								
YSI	1 YES 23 NO	13	OSPUAL:	ER/Outpa	itlent 3	□ DOA	4 Nun		e 5 🗆 R	lasidence	8 🗆 Other	(Specify)			
H	27. MANNER OF DEATH		28e. DATE OF I			28b. TIMI INJ	IE OF JURY	28c. INJ WO	URY AT		28d. DESC	RIBE HOW II	NJURY OC	CURED	
BY	Netural 5 Pending 2 Accident Investig						М	1 🗆 1	YES 2	□ NO	1 <u> </u>				
	3 Suicide 8 Could r		28e. PLACE OF building, e	INJURY -	— At horr	ne, farm, r	street, feci	lory, office				TION (Street a Town, State)		r or Rurel A	oute Number,
COMPLETE	4 Homicide determi	ned													
PL		PHYSICIAN	N: To the best of a	ny knowle	edge, dea	ath occurs	ed at the f	ilme, date	end plac	e, end due	to the ceus	e(e) end man	nner ee eta	ted.	
O.	one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner se stated.												end manner ee stated.		
ш	296. SINATURE AND TITLE OF CE	RTIFIER /	1				7		29c. LIC	ENSE NUM	ABER		29d. DAT	E SIGNED	(Month, Day, Year)
0	of beingtone	s 4	1, //2	m	14	. X			I	D 14	865		▶JU	JLY	19-95
2	30. NAME AND ADDRESS OF PERSO	/													
	DR. ROBUSTIA						L H	OSP:	ITA	L ME	DICA	L BL	DG.,	CUI	MBERLAND
	31. DATE FILED (Month, Day, Year)	395	32 HEGISTHAN	THE SIGNA	TUR	dall									

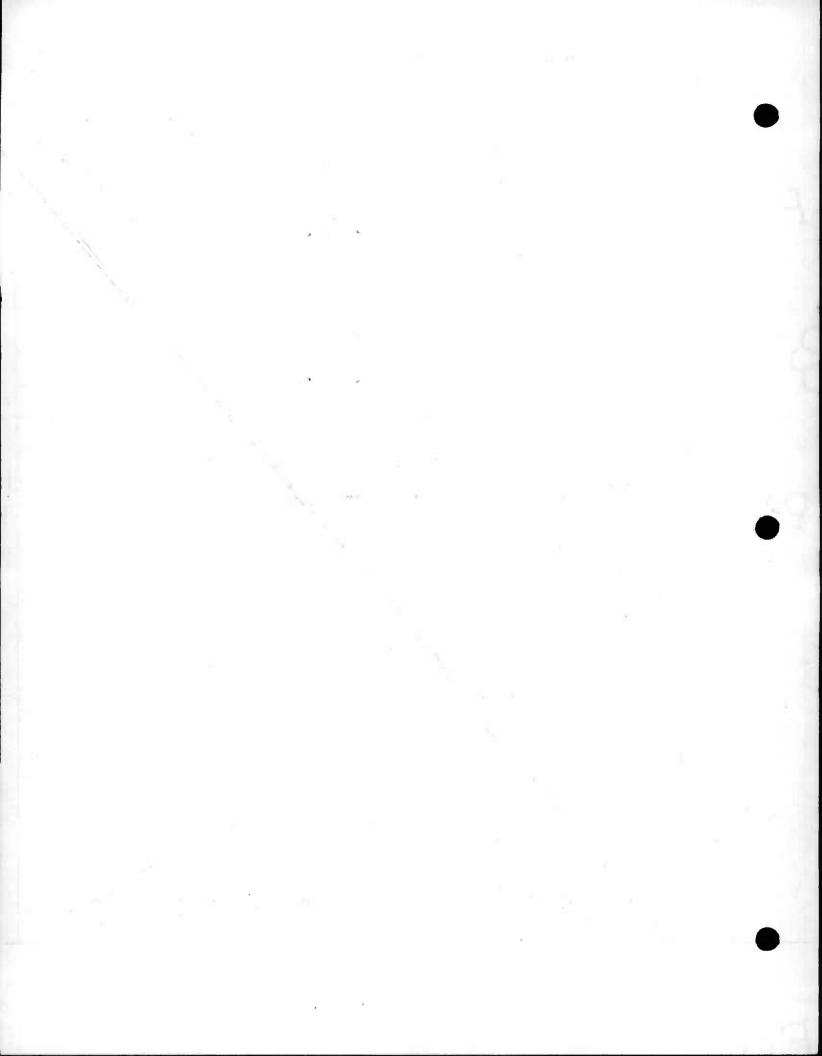
- de grape

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B.K.S

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-726 8/7/95 t.t

		1 - STATE REGISTRAR	STATE OF M		D / DEPAR CERTIF				D MEI	NTAL HYGIEN REG. NO.	E			
		1. DECEDENT'S NAME (First, Middle, Last)								DATE OF DEATH		EAR	TIME OF OEATH	
in the contract		ANGIE M. 4. SOCIAL SECURITY NUMBER	5. SEX	SNER 6. AGE (In vo	s. lest birthday)	IF UNDER	YEAR	IF UNDER 24 HF	$\overline{}$	JLY 1	4,199		0845 A M	
9		233-25-2367	1 □ M 2 💥 F	16		MONTHS	DAYS	HOURS MI	Ai	Month. Dev. 125,	1978	Country) Wes	t Virginia	
pinous		9a. FACILITY NAME (If not institution, give st	reet end number)			9b. CITY,	TOWN OF	LOCATION O	F DEATH					
1, 2, 3	CTOR	WASHINGTON COU	NTY HOS	PITAI		HAGI	ERST	OWN			WASH	ING	TON	
permit. Pages	DIREC	WV 106, COUNTY MOT				y, town or erkele		prings					Dd. INSIDE CITY LIMITS? TYES 2 NO	
it permit		100. STREET AND NUMBER Rt. 3, Box 133				-		zie code 5411					AT COUNTRY?	
or attending physician.	FUNERAL	11. MARITAL STATUS 1 X Never Married 2 Merried	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	MNO	1 11	AS DECE	NDENT OF HIS	xican, Pu	RIGIN? (Specify Yes ierto Rican, etc.)		. RACE — Black, V	American Indian, White, etc.	
attending use as the	ED BY	3 Widowed 4 Divorced 15. DECEDENT'S EDUC			. DECEDENT'S		CUPATION	71	pecify:	16b, KIND OF BUS		Specify:	White	
he hospital or att detached for use once.		(Specify only highest grade Elementary/Secondary (0-12)			(Give kind of a	work done di	uring most	of working		High S		THY		
by the be dett	BE COMPLE	110,402	esner			. 1		Patty	Anı	First, Middle, Meiden n Kenkir	1S			
ay be retained page 5 should be notified	5	190. INFORMANT'S NAME (Type/Print) Roger Lee Kes	ner		Rt. 3	BO:	(Street en	3 J.,	Berl	Number, City or Town Keley Spi	in State, Zia Co	WV	23411	
		20s. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	vat from State		CEAND DATE			-		DATE 20c. LOG 3,1995	Romn		, State WV	
r death. e funera al.		21. SIGNATURE OF FUNERAL SERVICE LIC	ensee 1mn	and	f	²² S	haff 30 E	er Fur ast Ma	iera.	Home, I	Inc.		757	
ed within 24 completely fill, al, cremation, event, the	7	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Deat disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF):												
th certificate be ending physician Il Hygiene prior t or other traus	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Discess or Injury thet initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												
requires that the signed by of Health and shows any Is	MEDICAL	PART II. Other significant conditions DID TOBACCO USE CONTR						UNCERT		PERFORI 1 YES 2	MED?	AM CO OF	ERE AUTOPSY FINDINGS ALLABLE PRIOR TO IMPLETION OF CAUSE DEATH? YEB 2 NO	
The laste has ate De	SICIAN:	25. WAS CASE REFERRED TO MEDICAL		28. P	LACE OF DEAT		nly one)	ONCERIA	AIIN L					
Certification the	PHYS	XXYES 2 NO	HOSPITAL:		t 3 □ DOA □	4 🗆 Nursi			_	Other (Specify)	I II III COO:-			
	BY PI	1 Natural 5 Pending 2 XX Accident Investigation	7-8-95	ly, Year)	4:00	P M	WOR	K? 1 S 2 (∑ NO		IVER IN AU			ISION	
TOR: A after of after of 28 Is	<u>e</u>	3 Suicide a Could not be determined	28e. PLACE Of building,	FINJURY — A	st home, term, a		ry, office			LOCATION (Street or City or Town, Store)	WV ROAD	NAY,	WASHINGTON	
Z Z Z =	OMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 X MEDICAL EXAMINER	IAN: To the best of	my knowledge	, death occurre	od at the tim	ne, date e Inlon, des	nd place, end th occured at	due to th	e ceuse(s) end men	ner es stated. I due to the ce	luse(s) er	nd menner es stated.	
TO THE HOSPI TO THE FUNER be filed within	TO BE C	THE AND TITLE OF CERTIFIER	Salle	1				O.C.					onth, Day, Year) 15 , 1995	
		MARIO TO GOOD	LE TE	WALI	Penn		eet	, Bal	Ltin	nore, Ma	aryla	nd :	21201	
		31. DATE FILED (Month, day, Year) 2 6 1995	32. REGISTRAI	R'S STGNATUR	E 4									



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within A hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

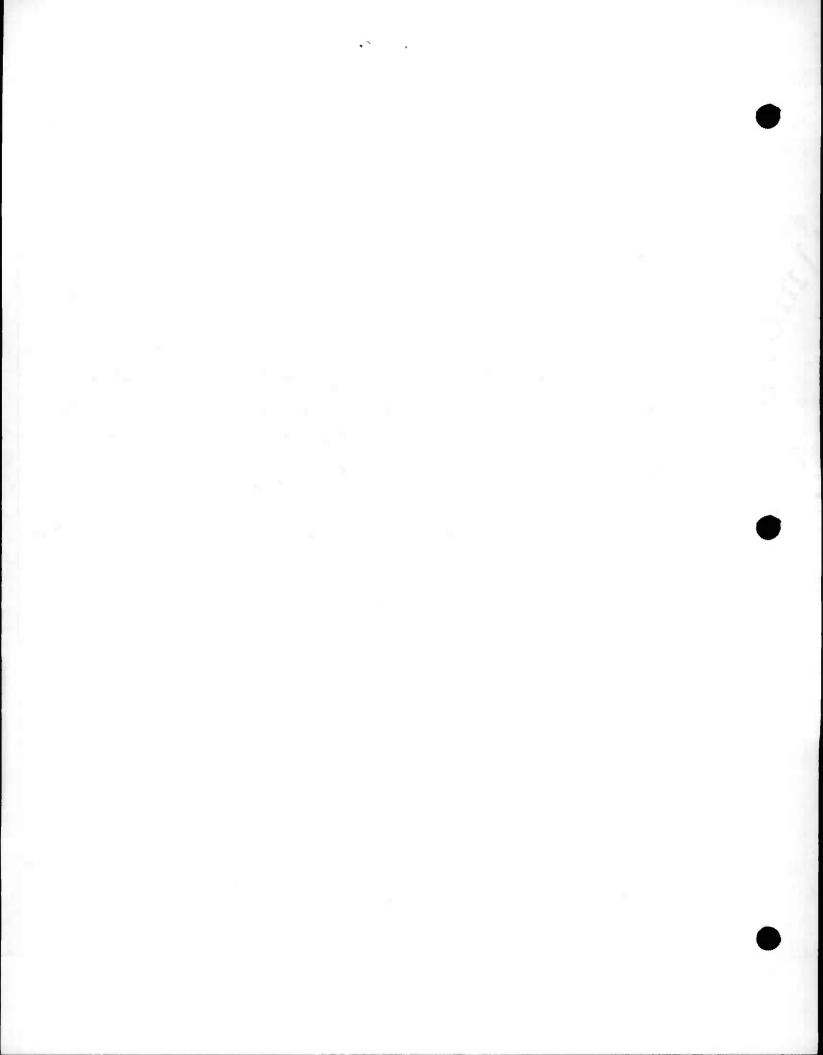
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	nedio Inan				Enill	ICALE	OF DEA	VI II	RE	EG. NO.				
	1. DECEDENT'S NAME (First ROBIN D		LEONARD			7	2. DATE OF D	DAY	DAY YEAR					
	4. SOCIAL SECURITY NUMBER		5. SEX	8. AGE (In yrs.	foot histories	IF IMPER 4 W			JULY		199		8:01 AM M	
	212-66-21		1 M 2XXX	40	YRS.	IF UNDER 1 Y	AYS HOURS	MIN.	7. DATE OF BI (Month, Day)	(Year)	955	Count	HPLACE (State or Foreign ry) RYLAND	
	9a. FACILITY NAME (If not in	stitution, give st	reet end number)			9b. CITY, TO	WN OR LOCAT	TION OF DE			9c. COU	_		
DIRECTOR	21611 EVE		DRIVE]	PREST	ON			CA	ROL	INE	
<u></u>	10e. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN OR	OCATION				10d. INSIDE CITY			
	MARYLAND	CARO	LINE		P	REST	ON				LIMITS? 1 YES 2 KNO			
Ž	10e. STREET AND NUMBER						10f. ZIP CO	DE			10g. CITt	ZEN OF	WHAT COUNTRY?	
9	21611 EV	ERLEA					21	1655				US	A	
FUNERAL	11. MARITAL STATUS 1 Never Merried 2 X	Married	12. WAS DECEDEN' FORCES? 1			13. WAS	DECENDENT	OF HISPAN	IIC ORIGIN? (Sp	ecify Yes o	or No-	14. RACI	E — American Indien, k, White, atc.	
BY	Specify: Specify:													
2														
S														
H														
2														
				20h BI AC		OF DISPOSITION		DKI		_				
	20e. METHOD OF DISPOSITI	n 3 Remo	oval from State	SPR	rematory or o	her place)	EMETE	PV	7-6	EAC		-	D 21601	
Ì	21. SIGNATURE OF FUNERA	L SERVICE LICI	ENSEE -	10210	^		ME AND ADDRI	_		EAD	TON	, I'II	7 21001	
	M. E.	Down	main	- CF	SP	NEV 200	NAM E	UNE	RAL HO	OME,	P.Z	A. STOI	N. MD	
	23. PART I. Enter the di	seasea, or co	omplications that	caused the	death. Do r	ot enter the	moda of dy	/Ing, auch	aa cardiac c	or reepira	tory arr	est.	Approximata	
	iMMEDIATE CAUSE (Fin	eart tenure. L	ist only one cau	se on each ii	ne.								Interval Batwean Onset and Death	
	disease or condition resulting in death)	.	RG	2-50	00		C31	100	112				2 725	
	resulting in death)		OUE TO	OR AS A CORS	EQUENCE OF	j:	41	7 - 7					- 120	
z	_													
CERTIFICATION	Sequentielly list conditi If any, leading to immed		DUE TO	OR AS A CONS	EOUENCE OF	ŋ:								
3	cause. Enter UNDERLYi CAUSE (Disease or inju													
	that initiated eventa		DUE TO	OR AS A CONS	EGUENCE OF):								
H	resulting in death) LAS	d	l											
	PART il. Other algnifica	nt conditions	contributing to	deeth but not	reeviting i	n the under	dvina causa	alven in i	Part i Tata	WAS AN AL	ITOROV	1 000	WISTE AUTODOX STUDIOS	
EDICAL							rying cadao.	given iii i		PERFORM		240.	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO	
									_ 1 🗆	YES 2	XVO		DF DEATH?	
Σ	DID TORACCO II	CE CONITO	UDLITE TO CAL	ICE OF DE	ATLL ME	c 🗆	NT				,		t 🗌 YES 2 🗌 NO	
A N	DID TOBACCO U		IBUIE IO CAI			S NC H (Check only		CERTAIN	<u> </u>					
ᅙ	EXAMINER?	MEDICAL	HOSPITAL:			OTHER:	-							
PHYSICIAN:	1 VES 2 NO		1 □ Inpatient 2 □					esidence i	8 Other (Spec					
		Pending	(Month, De		28b. TIM	URY	WORK?		28d. DESCRIBE	E HOW INJ	URY OCC	UREO		
à	2 Accident	nvestigation	200 BI ACE OF	IN ILIPV ALL		,	YE\$ 2	_ NO						
COMPLETED		Could not be letermined	building,	INJURY — At I	iome, ierm, s	treet, tactory,	Office		281. LOCATION City or Tow	l (Street end rn, State)	d Number	or Runsi R	loute Number,	
2	29e. CERTIFIER (Check only	IFYING PHYSIC	IAN: To the beat of	my knowledge,	death occurre	d at the time.	date end place	e, end due t	to the councies	end menne	er ga state	rd.		
8) and menner as stated.	
	2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(a) and menner as attated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)													
BE	A	16	CA.	0			17	(1)	225	'	DATE	7 1	(Month, Day, Year)	
유	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUSE	OEATH AT	EM 27) (7000	Print)	0						5-75	
	STEPHEN P	- CAR	NEY, M.	D., 5	09 II		LD AV	ENUE	, EAS	TON,	, MD	21	601	
	JUL 06		A REGISTRAT	R'S SIGNATURE	dall									



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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detached	Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
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BE COMPL

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29b. SIGNATURE AND TITLE OF CENTIFIER

10. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

					•	-									
												C	35	2322	4
		FOR 1 - STATE REGISTRAR	STATE OF I												
		1. DECEDENT'S NAME (First, Middle, Last)						-		2. DATE OF	DEATH			3. TIME OF DEA	TH
		JAMES	FRANCI	S			La11	- y		July	4		95	11:07	Ам
1			5. SEX		l birthday)					7. DATE OF	BIRTH		8. BIRTI	HPLACE (State or F	oreign
1				68	YRS.	MONTHS	DAYS	HOURS	MIN.	AUG.	15,1	L926	MAI	RYLAND	
	~								ON OF O			9c. COU	INTY OF C	DEATH	
	5		TAL]	EAST	ON_					TALI	вот	
Ì	E C				10c. CIT	Y, TOWN	OR LOCAT	ION						10d, INSIDE CIT	γ
1	<u>a</u>	MARYLAND TA	LBOT			ST.	MIC	HAE	LS						
	A	10e. STREET AND NUMBER					101	ZIP COD	E			10g. CIT	IZEN OF		
	<u> </u>	710 RIVERVIEW 1	TERRACE						216	63			USA		
		11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR	MEO	13.	WAS DEC	ENDENT C	OF HISPAN	NIC ORIGIN? (Specify Yes	or No-	14. RACI	E — American Indi	len,
Ì	₽ B	1 Never Married 3 Wildowed 4 Divorced 1 Yes, GIVE WAR OR DATES 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 YES 2 NO IF YES, GIVE WAR OR DATES													
1		15. DECEDENT'S EDUC	CATION	16a. DE	CEDENT'S	USUAL C	OCCUPATIO	IN.		16b. KI	ND OF BUS	SINESS/INC	DUSTRY		
	삨	Elementary/Secondary (0-12)		Life.	ive kind of a Do NOT us	work done se retired.)	during mo:	st of working	ng	1					
,	<u> </u>	12	4	PHO	OTOG	RAP	HER				NEWS	SPAP	ER		
	8	17. FATHER'S NAME (First, Middle, Last)													
	BE														
	2	process of the second												DT 6 16	
			TTT X						TER		_)
		1 Buriel 2 Cremetton 3 Remo	oval from State	20b. PLACE A	MD DATE	OF DISPO: ther place	DEM Z	me of VT∕D	v						
	İ		ENSEE	CAM	KIDG						CAL	TML	DGE	, FID	
	1	-									OME	, P.	A.		
-						2	00 5	. н	ARR	ISON	ST.	EA.	STO	N, MD 2	2160
		ahock, or heart failure. I	omplications the List only one cau	t caused the de ise on each line	ath. Do r	not enter	r the mod	de of dy	ing, auci	h aa cardled	or respi	ratory an	rest,		
	ł	IMMEDIATE CAUSE (Final	0.												
		resulting in death)	-st	Mis		_								San	44
	_		711000	OR AS A CONSEC	DUENCE OF	F):	N 1	-)	- 1		•		1. ()-	1
	ō	Sequentially list conditions,	DUE TO	(OR AS A CONSEC	UENCE OF	Pi:	يناي	7 1.	Wy	Home	Me	4		1400	45
	Y	cause. Enter UNDERLYING				,								j	U
	Ĕ	that initiated eventa	DUE TO	(OR AS A CONSEC	DUENCE OF	F):									
	ᇤ	reaulting in death) LAST	l												
	ᄀ	PART II. Other significant conditions	contributing to	death but not n	eaulting i	In the u	ndorlulno		sheep In	Dani I a					
	ই	PERFORMED? AVAILABLE PRIOR TO													
		1 - STATE THE TOTAL OF MAINT LATTER TO PEACH MEAN UP HEALTH AND MENIAL HYGINE REG. NO. 1 - DECEDENT PANABER 1 - LECTION TO PEACH		1 □ YES 2 NO DF DEATH?											
	Σ.	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE RECOND. STATE OF DEATH PRECOND.		Ю											
	¥	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)													
	Sic	The state of the s			· .	OTHE	R:	5 P-	aldenna	8 Other /O	neciful				
	ᅔ	27. MANNER OF DEATH	28e. DATE OF	INJURY	28b, TIM	E OF	28c. INJU	JRY AT				NJURY OC	CURED		_
	BY		(Month, D	ay, reer)	II/J				NO						
П	ali	3 Suicide 8 Could not be	28e, PLACE O building.	F INJURY — At horate. (Specify)	me, term, a	street, taci	tory, office			28f. LOCATIO	N (Street a	nd Number	or Rural F	Route Number,	_
Ш		4 Homicide determined		1-7-3-17						Oily or It	mii, stele)				

DIVILIO, 10, M.D., 404

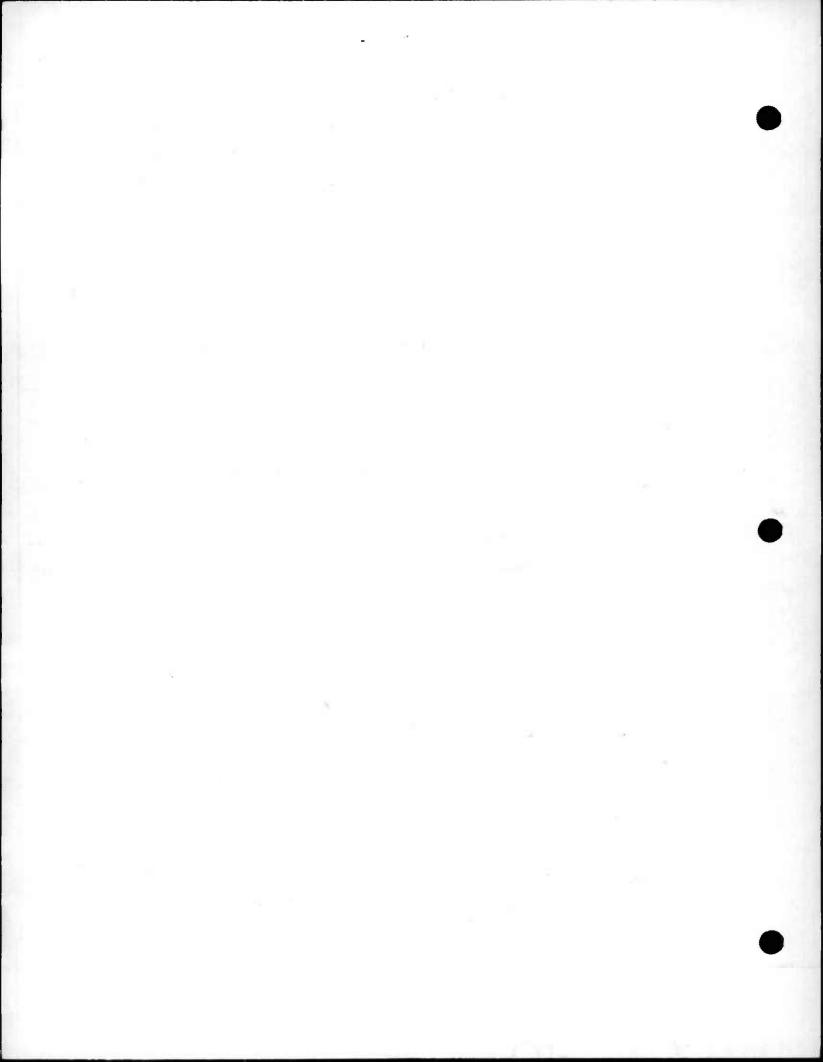
10, REGISTRATS SIGNATURE

1014 A DEVILUE TO ALLE THOMAS 404 MARVEL COURT, P.O. BOX 822, EASTON, MD 7.06 1995 21601

2 __ MEDICAL EXAMINER: On the besie of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the ceuse(e) end manner es stated.

29c. LICENSE NUMBER

29d. DATE SIGNEO (Month, Day, Year) 4195



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within trafficours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR TO BE COMPLETED BY FUNERAL DIRECTOR TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF													3. TIME OF DEA	ATM
JEAN	LABA	\mathbf{T}				July 18,	11:30	Р. "						
4. SOCIAL SECURITY NUMBER		5. SEX		(In yrs. les	t birthday)		R 1 YEAR	_		7. DATE OF BIRTH		a. BIRTI	HPLACE (State or	Foreign
217 36 579	1	1 🔀 M 2 🗌 F	75		YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) 9 29 19		MD	ry)	
9a. FACILITY NAME (If not in					9b. CITY, TOWN OR LOCATION O					ATH		UNTY OF DEATH		
110 w ch						st	mi	chael	S		1	CALBC	OΤ	
RESIDENCE OF DEC	10b. COUNTY	1			10c CITY	TOWN	OBLO	CATION						
md	TALB	OT			ST. MICHAELS							10d. INSIDE CIT LIMITS?		
10e. STREET AND NUMBER								101, ZIP COD			40- 01		1X YES 2 WHAT COUNTRY?	
110 W CHEW	AVE							2166				JSA	WHAI COUNTRY?	
11. MARITAL STATUS 1 Never Married 2 💢	Married	12. WAS DECEDEN FORCES? 1	YES	U.S. ARI	MED	13.	WAS D	ECENDENT (OF HISPAN	IIC ORIGIN? (Specify Yearn, Puerto Ricen, atc.)	or No-	14. RACI	E — American Inc k, White, atc.	dlen,
3 Widowed 4 Divo		IF YES, GIVE V	WAR OR D	ATES WW	II			ES 2 NO					WHITE	
15. DEC (Specify only	EDENT'S EDU y highest grade	CATION completed)		(Gh	CEDENT'S	ork done	during i	TION most of working	10	16b. KIND OF BU	SINESS/IN	DUSTRY	-	
Elementary/Secondary (0	⊢12)	College (1-4 or 5	+)	life.	EPIS			PRIEST	1	CHURC	H			
17. FATHER'S NAME (First, M JEAN J							MA	ME (First, Middle, Maiden ARIE STEWAL	RT					
190. INFORMANT'S NAME (7)		196	P O	box	S (Stree	134 ST	or Rural F	CHAELS MD	n, State, Zi 2166	Gode)				
20a. METHOD OF DISPOSITI 1	n 3 🗆 Remo	oval from State	20b cem	PLACEA CAPT	ND DATEO	FDISPOS	SITION (Neme of ORY		7-20-95 I	CATION — DOVE	City or To	wn, Stata	
21. SIGNATURE OF FUNERA	L SERVICE LIC					22.	NAME	AND ADDRE	SS OF FAC	YILITY				
Sparce	con K	Ea Le								NARD FUNE			ST MICE	IAELS
IMMEDIATE CAUSE (Findlease or condition resulting in death) Sequentielly list condition if any, leeding to immediates. Enter UNDERLY! CAUSE (Disease or injuing.)	Dna, diete	oue to	OR AS A	CONSEQ	UENCE OF		/ - ()	ar Jes	res	f ers Sele	W.	ioat,	Approxin Interval E Onset an	Batween
that initiated events resulting in death) LAS	•					7. 8		-						
PART II. Other algoritical	1 mo	Cona/	/		eaulting in		nderlyl	ng cause (jiven in i	Part I. 24a. WAS AN PERFOR 1 TYES 2	MED?	246	. WERE AUTOPSY I AVAILABLE PRIOR COMPLETION OF OF DEATH?	R TO CAUSE
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL						PLACE OF D	EATH (Che	ck only one)				-
1 TYES 2 NO		HOSPITAL:	ER/Outp	atlent 3		OTHEI		ome 5 Re	aldenca	8 Other (Specify)				
	Pending nvestigation	28a. DATE OF (Month, D			28b. TIME INJU	OF	28c. If	NJURY AT VORK?		28d. DEŞCRIBE HOW II	NJURY OC	CURED		
3 Suicide a	Could not be	28s. PLACE Of building,	F INJURY atc. (Speci	— At hom	ne, farm, at	reet, fact	tory, off	lica		281. LOCATION (Street a City or Town, State)	nd Number	or Rural P	Route Number,	
29a. CERTIFIER (Check only one) 2 MEDIC	IFYING PHYSIC	CIAN: To the best of	my knowle	edge, des	th occurred	at the t	lime, de	te and place,	and dua	to the cause(a) and man	ner as ate	led.) and menner es	atated
29b. SIGNATURE AND TITLE 30. NAME AND ADDRESS OF	OF CERTUFIER	tim	6	(1	>			NSE NUM				(Month, Day, Year)	
Terry P.	Detric	h M.D.	140	s.	Wash		ton	St. E	Easto	on, Maryla	nd 2	21601		
31. DATE FILED (Month, Day,	2 0 199	5 Java	PIS SIGN	TURE P	irefalle									

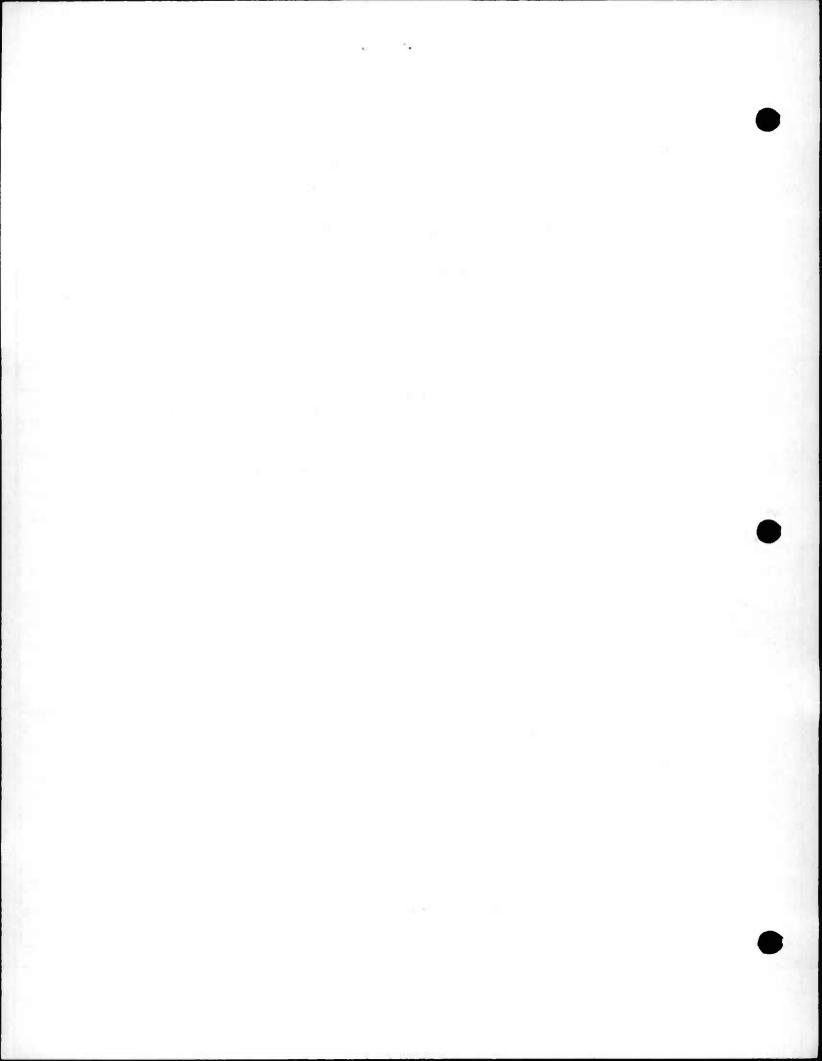
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fter death. Page 6 may be retained by the	Should	
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death	atten	ental h
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Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires the TO THE FUNERAL DIRECTOR: After this certificate has been signed by a study of the Allenth of the State Dear of Health by a study of Health by the State Dear of Health by the Allenth by the Allenth by

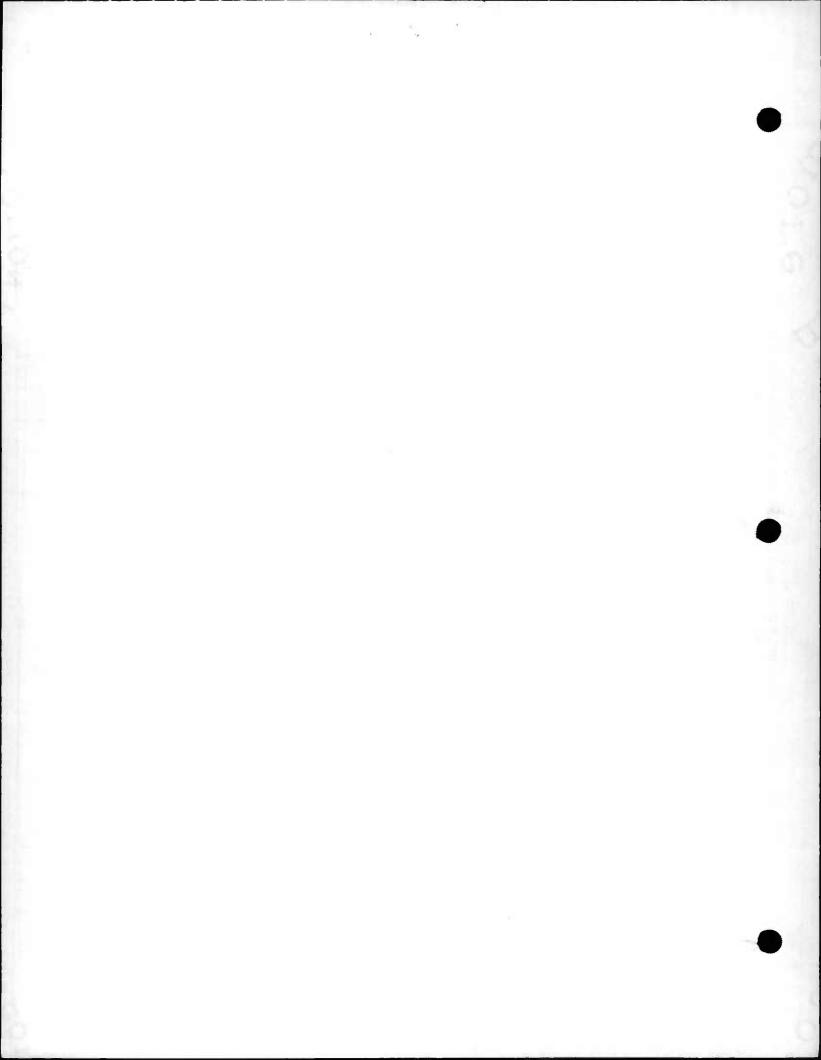
DIVISION OF VITAL RECORDS, P.O. BOX 68760

		1 - FOR STATE REGISTRAR	STATE OF MARYLAND			HEALTH AND F DEATH	MENTA	AL HYGIEN	E						
	- A	1. DECEDENT'S NAME (First, Middle, Lest) The 1	.ma C.		Lee		MON		Y 10	3. TIME OF DEATH					
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs.	lasi birthday)	IF UNDER 1 YEAR		J U	L OF BIRTH		95 3:32 PM BIRTHPLACE (State or Foreign					
	1		1 □ M 2 💢 F 81	YRS.	MONTHS DAYS	HOURS MIN.	NOV	7.6, Year)	913	MARYLAND					
	Œ	90. FACILITY NAME (If not institution, give stre				N OR LOCATION OF	DEATH		9c. COUNTY						
	5	MEMORIAL HOSP	LTAL		E	ASTON			1	ALBOT					
	DIRECTOR	MARYLAND TALE	O C m	10c, CITY	TOWN OR LOC				10d. INSIDE CITY						
		10e. STREET AND NUMBER	301		EASTO	10f. ZIP CODE			10a. CITIZEI	1 TYES 2 X NO					
	FUNERAL	27963 WOODS I				216	01			USA					
	BY FUI	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES THE IF YES, GIVE WAR OR DATES	ARMED	If yes,	ECENDENT OF HISPA specify Cuban, Mexic ES 2 NO Spec	can, Puerio	N? (Specify Yee Rican, etc.)	or No- 14	. RACE — American Indian, Black, White, etc. Specify: WHITE					
	9	15. DECEDENT'S EDUCA (Specify only highest grade or		DECEDENT'S	USUAL OCCUPA	TION	16	b. KIND OF BUS	INES\$/INDUS						
	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	HOMEM	retired.)			OM	N HOM	112					
once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		понц	MILK	18. MOTHER'S N	AME (First,			UE ₁					
at of	BE	NATHAN B. CARTI													
be notified at	5	NATHAN B. CARTER 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS B. SEWELL 2720 BAINES COURT, CROFTON, MD.													
		20a. METHOD OF DISPOSITION	20h PLAC		FDISPOSITION		T, C			or Town, State					
Ē		1 X Burial 2 Cremation 3 Remov 4 Donation 5 Other (Specify)	GREE	NMOUN	T CEM		7-22			O, MD					
a. I examiner must		21. SIGNATURE OF FUNERAL SERVICE LICENSEE White Williams TD CFSP 22. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EAST													
or removal medical		23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reepiretory arrest, shock, or heart fellure. List only one cause on each line. Approximate interval Between													
the in		IMMEDIATE CAUSE (Fine) disease pr condition Respiratory Failure													
event, the	ı	DUE TO (OR AS A CONSEQUENCE OF):													
imatic e	S	Sequentielly list conditions, b.	ARDS							1 Week					
2 5	ATI	If any, leading to immediate ceuse. Enter UNDERLYING	Pneumonia);					2 57 - 1					
other	RTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONS):					2 Weeks					
5 5	CER	d.													
and Menta ny injury.	CAL	PART II. Other eignificent conditions None	contributing to deeth but not	t resulting in	the underly	ng ceuse given in	n Part i.	24a. WAS AN /		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO					
E 60								1 X YES 2	□ NO	OF DEATH?					
23 shows	N.	DID TOBACCO USE CONTRI	BUTE TO CAUSE OF DE	ATH YES	5 NO 1	☑ UNCERTA	IN 🗆			1 X YES 2 □ NO					
item 2	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PL/		Check only on	•)									
e 5	HYS	1 YES 2 NO 1	28e. DATE OF INJURY		4 - Nursing Ho	ome 5 Residence	7	or (Specify) SCRIBE HOW IN	UPW ACOUR						
is marked,	ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yeer)	INJU	IRY V	VORK?	280. UE	SCHIBE HOW IN	JUHY OCCUM]					
28 m	8	3 Suicide 6 Could not be detarmined	28e. PLACE OF INJURY — At I building, etc. (Specify)	home, term, st	reet, fectory, off	lca	261. LOC City	CATION (Street ar or Town, State)	nd Number or F	Rural Route Number,					
item	COMPLET	29e. CERTIFIER (Check only 1 K CERTIFYING PHYSICIA	AN: To the best of my knowledge, o	death occurred	st the time, de	te end place, end du	e to the ca	use(s) end menr	ner ee atated.						
IMPORTANT: If I	OM		On the basis of examination and/o							suse(e) end manner ee stated.					
PORT	H	296. SIGNATURE AND TITLE OF CERTIFIER	0 1000	-00	44	29c. LICENSE NU			29d. DATE SI	GNED (Month, Day, Year)					
8 ₹	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (IT	EM 27) (Type. I	Print)	D 3463	3		Jul	y 18, 1995					
		Reinhardt Sahme	el MD Memor:	ial H		al Eas	ton,	Maryla	and 2	1601					
		JUL 2 0 1995	31. REGISTAAR'S SIGNATURE	tall											



1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First	Miridia (nat)		-			IOATI		DLAI	111		HEG. NO.					
		CARROLL	G.	LINDS	CλV							JULY	OF DEATH	1995	EAR 3.	:00 P		
		4. SOCIAL SECURITY NUMBER		5. SEX		(In yrs. last	hirthday	IF UNDER	1 VEAD	IF UNDER 2	24.4820	7. DATE O				-		
		212-18-64	2/1	t 🔀 M 2 🗆 F	o. Hull	76	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month	Day. Year) 5,1918		Country)	ACE (State or Foreign		
pino		9a. FACILITY NAME (If not in		43		10		ah CITO	/ TOWN /	OR LOCATIO			,1910	9c. COUNT	Mary			
3 should	<u>د</u>	Perry Poi			1				ryvi		IN OF DE	AIH				гн		
1, 2,	DIRECTOR	RESIDENCE OF DEC		Tiospita				rer	Lyvi	ille				Ceci	Ţ			
ages	H.	10a. STATE	10b. COUNTY				10c. CIT	Y, TOWN	OR LOCA	TION					10	Id. INSIDE CITY		
# <u></u>		Maryland	Tal			Ea	ston							YES 2 NO				
5	1AL	10e. STREET AND NUMBER								f. ZIP CODE				10g. CITIZE	N OF WHA	AT COUNTRY?		
-0020 ling physician. the burial-transit permit. Pages 1,	FUNER	116 Goldsbo	rough					_ 2	21601				U.	S.A.				
20 ysicia	15	11. MARITAL STATUS 1 Naver Married 2	Manufad	12. WAS DECEDEN FORCES? 1	XYES	U.S. ARI	MED D	13.	WAS DEC	ENOENT OF	HISPAN	IIC ORIGIN	(Specify Yea	or No-		American Indian, /hila, atc.		
6 g g	BY	Widowed 4 Divo		if yes, give v Army	VAR OR D	ATES				2 X NO	Specify		icuit, atto.)	1	Specify: White			
215-0020 attending physician. se as the burial-trar	ED		EDENT'S EQU		AAAAT		EOFNITIO	USUAL O	OCHIOATI	041		For				willte		
or at	I E	(Specify ont	y highest grade	completed)		(Gh	m kind of	work done se retired.)	during mo	ost of working	7	16b.	KIND OF BUS	INESS/INDUS	TRY			
D spital ed fo	12	Elementary/Secondary (0	I-12)	College (1-4 or 5	"	100		al B	usir	1888		Se	elf-Em	nlowe	4			
LAND 21215 the hospital or attend detached for use as	COMPLET	17. FATHER'S NAME (First, M	iddle, Lest)			Cas		W. D	ub11		FR'S NAI	_	iddle, Maiden S					
Y # 8 %		Alber	t Lind	say			Margaret Nash											
MARN retained b) BE	19a. INFORMANT'S NAME (7				19b	19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
be rett	2	Catherine 1	Diane	Bryan			P.O. Box 239 St. Michaels, Maryland 21663								663			
	1	20e. METHOD OF DISPOSIT	ION	ovel from State	20b	PLACEA	ACE AND DATE OF DISPOSITION /Name of DATE 200 LOCATION City of Town State									State		
BALTIMORE after death. Page 6 may by the funeral director, pa moval. ical examiner must b		1											/aryl	and				
ALTIN death. Pag b funeral dia l.		22. NAME AND ADDRESS OF FACILITY Harrison E. Leonard Funeral Home 216																
SAL r dear ne fun al		Tanua C. Clarerel 312 S. Talbot St. St. Michaels, Maryland																
ta Ser Ser		23. PART I. Enter the diseases, pr complications that caused the death. Do not anter the mode of dying, such as cerdiec or respiratory errest, Approximate																
A S S S E		anock, or hi	aart tallure.	Liat only one cau	ISO ON O	ach line.										interval Between Onset and Death		
ely fil		disease or condition	→	S	epsi	s												
ompletely fille		DUE TO (OR AS A CONSEQUENCE OF):																
executed with and completely fille o burial, cremation, the mails event, the		Sequentielly list conditi																
BOX 68 ate be execute tysician and comprise to buring traumailic	CERTIFICATION	If any, leading to imme	diate	DUE TO	(OR AS A	CONSEO	UENCE O	F):										
	5	CAUSE (Disease or injury CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF):																
certificat ding phy typiene p	<u>E</u>	that initiated eventa resulting in death) LAS	т	502 10	(OH AS A	CONSEC	DENCE O	r):								İ		
DS, P. he death of the attend Mental Hy miury. or	E E		-	d														
	A	PART II. Other algnifica	nt condition	a contributing to	death b	ut not re	sulting	In the ur	deriyin	g cause gl	ven in i	Part 1.	24a. WAS AN A			RE AUTOPSY FINDINGS AILABLE PRIOR TO		
ECORD ulres that the signed by the Health and N. Health and N. W. anv Ini	MEDICAL											_	1 TES 24		CC	MPLETION DF CAUSE DEATH?		
									_							YES 2 NO		
AL RECO he law requires the has been signed Dept. of Health	ä	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE O	F DEA1	H YE	S 🔲 I	NO [UNCE	RTAIN	1 🔀						
ITAL V: The law cate has State Depr State 23	S	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		28. PLACE	OF DEA											
> 4 5 8 6		1 TES 2 XNO		1XXnpatient 2	ER/Oulp	etlent 3	DOA	OTHER		e 5 🗆 Resi	idenca	8 Other	(Specify)					
PHYSIC SE With the se	품	27. MANNER OF DEATH 1 ANotural 5	Pending	28a. DATE OF (Month, D			28b. TIM INJ	URY	28c, INJ WO	URY AT	[28d. DE\$0	RIBE HOW IN	JURY OCCUP	RED			
NG PHYS frer this ceath with	B		investigation					М		YES 2 🗌	NO							
DIVISION DR ATTENDING DIRECTOR: After hours after death			Could not be	28e. PLACE O building,	etc. (Spec	— At hon	ne, farm, a	streel, fact	ory, offic	•		28f. LOCA City of	TION (Street ar Town, State)	nd Number or	Rural Route	Number,		
DIVISION OR ATTEND DIRECTOR: A hours after the control of the cont	<u> </u>							-										
3 30 =	14			CIAN: To the best of														
HOSPITAL FUNERAL WITHIN 72	COMPLET	2 MEDI		R: On the basis of e	xamination	and/or In	veatigatio	n, in my o	pinion, d	eath occure	d st the t	time, date a	ind pleca, and	dua to the o	euse(s) an	d manner as stated,		
HE HE HE ORTE	BE	296. SIGNATURE AND TITLE	OF CHRISCH							29c. LICEN	ISE NUM	IBER		29d. DATE S	IGNED (Mo	onth, Day, Year)		
TO THE HOSPITY TO THE FUNERA Be filed within 7	0	Ta	-	_		D32395 ► 7/8/					8/95							
		30. NAME AND ADDRESS OF							_				034	200				
		THOMAS FI	NUCAN,	M.D., V	A Me	dica.	т Се	nter	, Pe	rry P	01n	C, MC	1. 219	902				
		31. DATE FILED (Mogth, Day	1 1995	Jalu do	wells	(Rano	Call											
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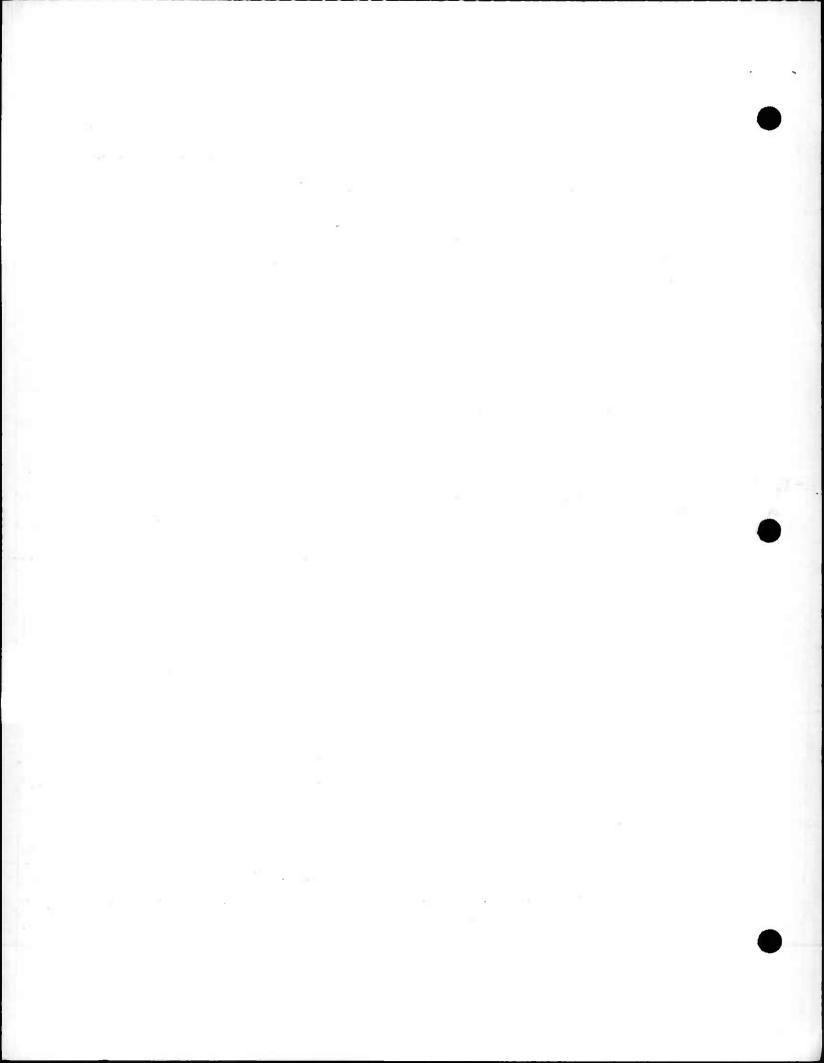
DIVISION OF VITAL RECORDS, P.O. BOX 68760, S BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIFI	TMENT OF H	HEALTH AND M	ENTAL HYGIEN						
	1. OECEDENT'S NAME (First, Middle, Last)	JAMES MIL				2. DATE OF DEATH DO NONTH DO NOTH DO N		3. TIME OF DEATH 9 10 P M				
	4. SOCIAL SECURITY NUMBER 2 1 8 - 2 0 - 4 3 7 8	1½ M 2 □ F	(In yrs. last birthday) 86 yrs.	# UNDER † YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 0 8 / 3 1 / 0 8	8. [BIRTHPLACE (State or Foreign Country) arvland				
TOR	9a. FACILITY NAME (If not institution, give s 635 Liberty Roa RESIDENCE OF DECEDENT				ralsbur		9c. COUNTY					
DIRECTOR	10e. STATE 10b. COUNT	oline	10c. CITY	, TOWN OR LOCAT		alsburg		10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	100. STREET AND NUMBER 635 Liberty	Road		101	2 1 6 3 2	2		of what country? ed States				
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3. Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 TYES IF YES, GIVE WAR OR D	2 XNO	If yes, sp	ENOENT OF HISPANIC ecity Cuban, Maxican, 2 NO Specity:	ORIGIN? (Specify Year Puarto Ricen, atc.)		RACE — American Indian, Black, White, etc. Specify: White				
PLETED	15. OECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 1 2 t h	CATION completed) College (1-4 or 5+)	18e. DECEDENT'S I (Give kind of w life. Do NOT use Home B	ork done during mo e retired.)		16b. KIND OF BUS	ructi					
E COMPL	17. FATHER'S NAME (First, Middle, Last)	harles S.	Long			E (First, Middle, Maiden						
TO BE	19e. INFORMANT'S NAME (Type/Print) Charles S. Lo	ng			and Number or Rural Ro	ute Number, City or Town	n, State, Zip Coo	, MD 21632				
	20e. METHOD OF DISPOSITION 11 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State cen	PLACEAND OATEO netery, crematory or off ill Cre	F DISPOSITION (Na her place)	ime of	OATE 20c. LO	CATION City					
	22. NAME AND ADDRESS OF FACILITY Framptom-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632											
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reaulting in death) DUE TO (OR AS ACONSEQUENCE OF): Approximate interval Betwee Opeat and Decided States of the condition of the co											
ERTIFICATION	Sequentially liat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. OUE TO (OR AS A CONSEQUENCE OF):											
MEDICAL C	PART II. Other alignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FI AMAILABLE PRIOR											
AN	DID TOBACCO USE CONT		F DEATH YES		UNCERTAIN			1 YES 2 NO				
YSIC	EXAMINER? 1 YES 2 NO 27. MANNER OF GEATH	HOSPITAL: 1 Inpatient 2 ER/Outp	eatlent 3 DOA	OTHER: 4 Nursing Hom	/							
ву рн	17 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	M 1 🗆 Y	RK? /ES 2 NO	red. DESCRIBE HOW II						
ETED	3 Suicide 8 Could not be 4 Homicide datermined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, at	reet, factory, office	2	181. LOCATION (Street a City or Town, State)	nd Number or R	ural Route Number,				
COMPL		CIAN: To the best of my know R: On the basis of examination						use(e) end menner ee stated.				
B	29b. SIGNATURE AND THE OF CERTIFIER	20. 0	X		29c LICENSE NUMB	2-25	29d. DATE SIG	GNEO (Month, Day, Year)				
임	30. NAME AND ADDRESS OF PERSON WH Stephen Car	O COMPLETED CAUSE OF OE	ATH (ITEM 27) (Type, I	Print) wild A	Ive Ex	STON, M	0 21	601				
	31. OATE FILEDIUT 197, 0°1995	A. REGISTRAR'S SIGN.				-						

1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH
Dwavne	Allen Lambert	MONTH DAY

		A DECEDENTIS NAME (51-)	Address to as					IOAIL	. 01	<u> </u>		HEG. NO			
	1 3	1. DECEDENT'S NAME (First,										2. DATE OF DEATH DON'TH D	AY	YEAR	3. TIME DF DEATH
		4. SOCIAL SECURITY NUMB	vayne	Allen 1								- C	5 1	995	2100 M
				5. SEX	6. AGE		t birthday)	IF UNDER	1 YEAR	HOURS	R 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		Country	PLACE (State or Foreign
D	1	213-04-03		1 <u>√</u> M 2 ∏ F		16	YRS.			, noons		Apr. 16, 1	979	PENI	ÍSYLVANNIA
3 should		9a. FACILITY NAME (# not in:	stitution, give si	reet and number)				9b. CITY	TOWN	DR LOCAT	ION DF DE	ATH	9c. CDU	INTY OF DE	EATH
, 3	CTOR	DEATON SPE	CIALI	TY HOSE	ATI	L &	HOME	BA	LTI	MORE	Ε		C	TY	
-	5	RESIDENCE OF DEC	EDENT												
ages	DIRE	10a. STATE	10b. COUNTY	,			10c. CIT	Y, TOWN D	R LOCA	TIDN					10d. INSIDE CITY LIMITS?
Ä.		MARYLAND	CA	RROLL			WE	STM	INS	TER					1 - YES 2 X NO
Decl	AL	10e. STREET AND NUMBER							10	H. ZIP COD			10g. Ci1	IZEN OF W	HAT COUNTRY?
burlai-transit permit. Pages	原	138 LIBER	TY ST	•						211	157		Į	JSA.	
Tal-tr	FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN FDRCES? 1	T EVER	N U.S. AR	MED					IC DRIGIN? (Specify Yes	or No-	14. RACE	— American Indian,
ž		1 Never Married 2 3 Wildowed 4 Divo	11.00	IF YES, GIVE V	WAR OR D	ATES	*0			S 2 A ND		n, Puarto Rican, etc.)		Specif	, White, etc.
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8	A P	0]	Non	e					
once.	COMPL	17. FATHER'S NAME (First, Mi	ddle, Last)							18. MOT	HER'S NA	ME (First, Middle, Maiden	Sumame)	_	
3 5	ш	CHARLES H. LAMBERT, JR. CARLOTTA DELLOSPEDALE													
notified	В	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Aural Route Number, City or Town, State, Zip Code)													
2	욘	19a. INFORMANT'S NAME (Type/Print) CHARLES H. LAMBERT, JR. 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 138 LIBERT ST., WESTMINSTER, MD. 21157													21157
t be		20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of													vn. State
must		1X Suriel 2 Cremetion 3 Removed from State													
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e tuneral dir I. Examiner		FLETCHER FUNERAL HOME													
by the funeral director, smoval.		254 E. MAIN ST. WESTMINSTER, MD.21157													
the attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or removal njury, or other traumatic event, the medical		23. PART I. Enter the discrete, or complications that caused the deeth. Do not enter the mode of dying, euch ee cardiec or respiratory arreet, shock, or hear feliure. List only one cause on each line.													
o, or		INNERIATE CAUCE (First													
ompletely fill il, cremation, event, the		disease or condition VEC													
crem vent		resulting in death) Out TO (OR AS A CONSEQUENCE OF):													
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Hygi or o	ᇤ	resulting in death) LAST													
ental ental	ᄬ			*											
th and Menta any Injury,	MEDICAL	PART II. Other eignificer	nt condition	e contributing to	deeth b	ut not r	esuiting	in the un	deriyin	g ceuse	given in I	Part I. 24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
Health and Indonesia Indon	용											1 D YES 2	0.0		COMPLETION OF CAUSE DF DEATH?
Heal Heal	I I												7		1 YES 2 NO
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s certificate has been s th the State Dept. of H id, or item 23 show	¥.	25. WAS CASE REFERRED TO						TH (Check of	-						
Stat	Sic	EXAMINER?	`	HOSPITAL:	ER/Outp	atient 3	□ DOA	OTHER		ne 5 🗆 Re	asidence i	B ☐ Other (Specify)			
d, o	PHYSICIAN:	27. MANNER OF DEATH		28e. DATE DF	INJURY		28b. TIM	E OF		JURY AT		28d. DESCRIBE HDW II	NJURY OC	CURED	
3 2			ending	(Month, D	ay, Year)		tNJ	URY		PRK?	ND I				
	В	2 Sulatta	nvestigation	28e. PLACE D	F INJURY	— At hor	me, farm.	tireet, fecto				28f. LOCATION (Street I	and Number	r or Rural Pr	nute Mumber
after d	ETED		Could not be letermined	building,	etc. (Spec	cify)			.,,		ŀ	City or Town, State)	ING PERIOD	or noral no	oute Number,
hours after item 28 i	<u> </u>	29a. CERTIFIER				_									
1 2 m	AP.	(Check only										to the cause(e) and mer			
N in	COMPL	2 MEDIC	CAL EXAMINER	R: On the baels of a	kaminatio	n end/or l	nvestigatio	n, in my o	elnion, d	seath occur	red at the t	time, deta and place, an	d due to ti	he cause(s)	and manner as stated.
filed within 72 h		296 SIGNATURE AND TITLE	DF CENTIFIER	00.						29c. LICI	ENSE NUM	BER	29d. DAT	E SIGNED	(Month, Day, Year)
De file	H	(dom C.	_ ~~~	Clau	hus	\cdot				D	3117	260	1	11.4	17 1995
- a =	2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
	ŀ	BRIAN	C. u	JALLA	CE	nut	1/	11	5. (CHA	LLE	3 ST. B	ACT	lux	LE MID 21230
		31. DATE FILED (Month, Day, Year) (1) Age. REGISTRAND SIGNATURE													
		JULI 7 199	5 your	Anmarian	Martin a	4						,			



IVISION OF VITAL RECORDS, P.O. BOX 68760, S BALTIMORE, MARYLAND 21215-0020	r death. Page 6 may be retained by the hospital or attending physician.
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FOR STATE REGISTRAR **CERTIFICATE OF DEATH** 1. OECEDENT'S NAME (First, Middle, Lest) 3. TIME OF DEATH 2. DATE OF DEATH 1995 10 Olive Marie Lippoldt 0 7 7:00 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DAYS NOURS 215/28/3305 1 M 2 F 64 06/11/1931 VRS Maryland permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR 13 Front Street Pocomoke City Worcester RESIDENCE OF DECEDENT 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Worcester Pocomoke City 1 YES 2 NO 10e, STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13 Front Street burial-transit 21851 USA 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Maxican, Puerto Rican, atc.)
1 YES \(\subsection \) NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 X Married Specify: White B 3 Widowed 4 Divorced the as a ETED 15. DECEDENT'S EDUCATION
Decily only highest grade completed) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) use 16b. KIND OF BUSINESS/INDUSTRY (Spec for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL detached 12 Teacher Education Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 2 notified at <u>Elisha W. Dunker</u> BE Ada Huber page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 2 Curt Lippoldt 13 Front Street, Pocomoke, Md. **21851** pe 20a, METHOO OF DISPOSITION
1 Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must DATE funeral director, St. Mary Episcopal Cemetery 7/13 Pocomoke City, Md. 4 Oonation 5 Other (Specify) medical examiner 21 SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Melson Funeral Home PO Box 64, Pocomoke City, Md. 21851 in by the 23. PART I. Enter the diseeses, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory erreet, Approximate shock, or heart fellure. List only one cause on each line. interval Between ŏ completely filled IMMEDIATE CAUSE (Final Onset end Deeth cremation, item 23 shows any injury, or other traumatic event, the disease or condition OVARON CONCER resulting in deeth) burial, CERTIFICATION and Sequentielly list conditions, OUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): the attending p thet initiated events resulting in deeth) LAST PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS signed by t Health and AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 - YES 2 X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) certificate h HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 TYES 2 TONO 4 Nursing Home 5 Residence 8 Other (Specify) ŏ 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? After this co 28 is marked, 28d. DESCRIBE HOW INJURY OCCURED Naturel 5 Pending 1 YES 2 NO В 2 Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number. City or Town, State) COMPLETED 6 Could not be OR ATTEND DIRECTOR: / 4 Homicide TO THE HOSPITAL OR ATTY
TO THE FUNERAL DIRECTE
De filed within 72 hours at
IMPORTANT: If Item 2 29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, data and placs, and due to the cause(e) and manner ee stated. 296. SIGNATURE AND TITLE OF GERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE aly D2487 95 2 60. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Fleury, MD - Cedar & Tenth Streets, Pocomoke City, Md. 21851 31. OATE FILEO (Month, Day, Year)

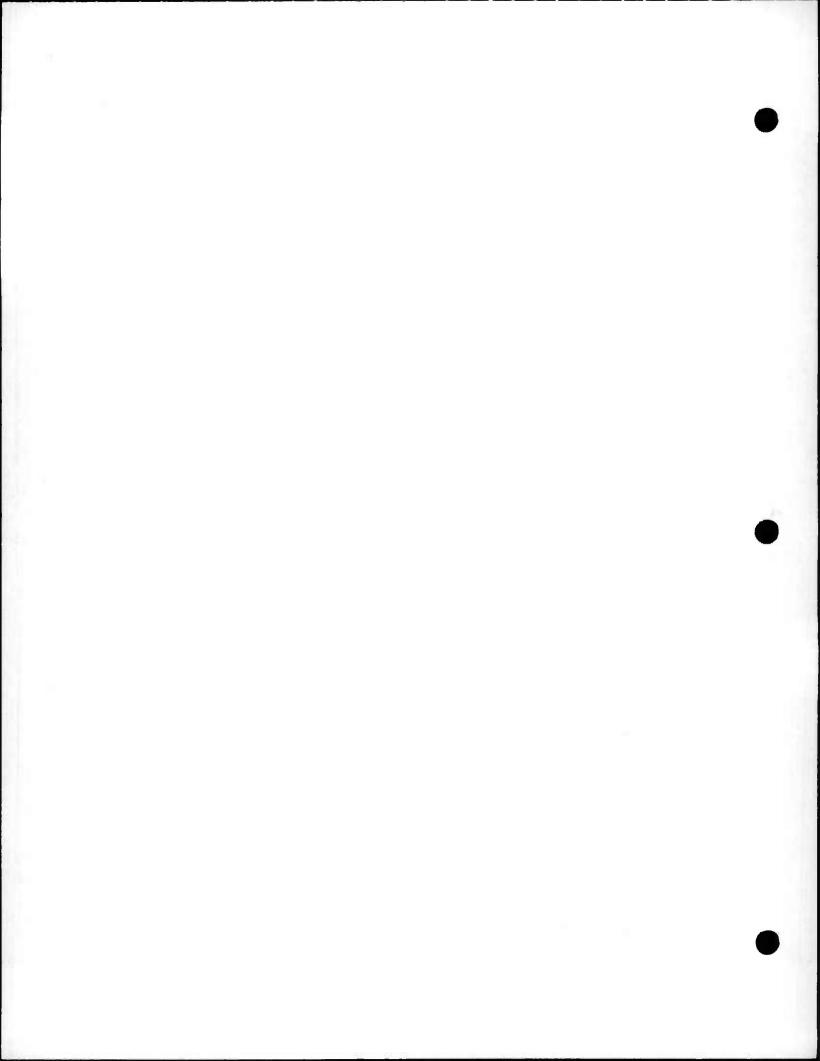
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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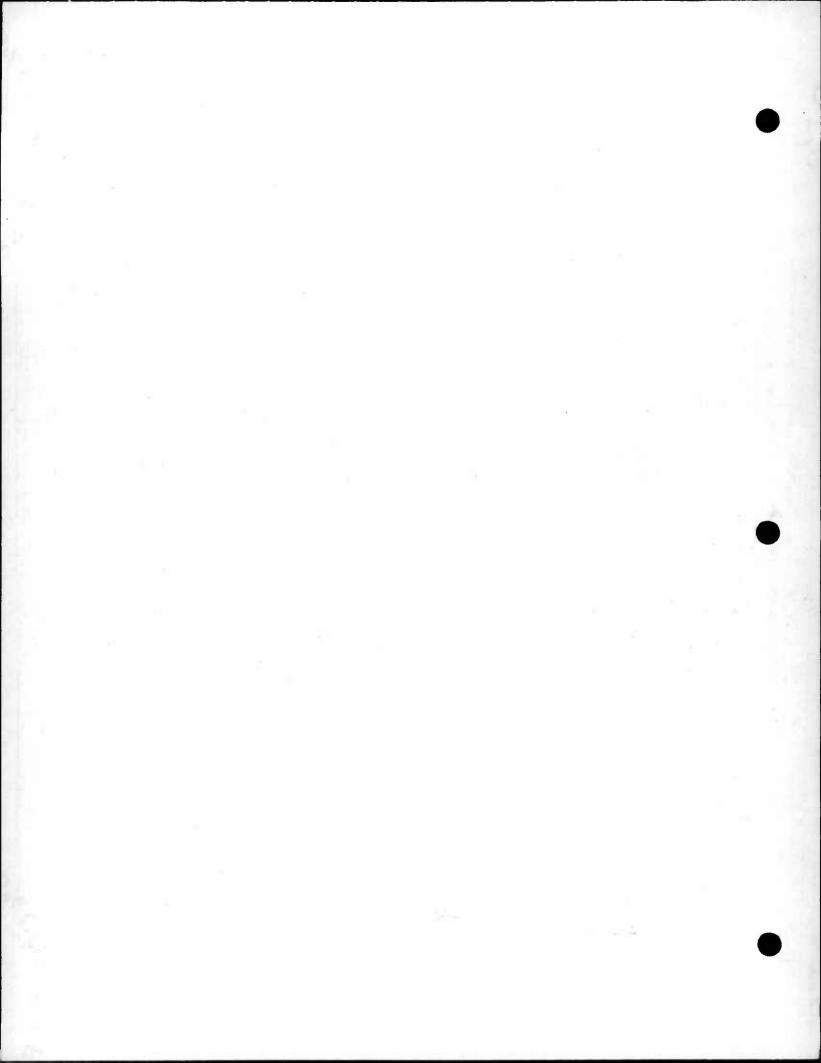
DIVISION OF VITAL RECORDS, P.O. BOX 68760

	FOR		CTATE OF	MADVI AND	/ DEDA	T10-117						_	J į		
	1 - STATE REGISTRAR	_	SIAIE UF I	MARYLAND C	ERTIF	ICATE	OF	DEA	AND I	MENTAI	REG. NO.				
	1. DECEDENT'S NAME (First,	, Middle, Last)		_						2. DATE	OF DEATN		YEAR	3. TIME OF DEATH	
	EDWARD	AUGUS'		ISELLE						Jul:	y 15,		TEAN	9:20 Am	
	4. SOCIAL SECURITY NUMB		5. SEX	8. AGE (In yrs. I		IF UNDER	1 YEAR	IF UNDER	MIN.	7. DATE ((Month	OF BIRTN , Day, Year)		8. BIRT Coun	HPLACE (State or Foreign try)	
	213-03-289			91	YRS.					eorgia					
Œ	Citizens N						1	DR LOCATI		EATH					
5	RESIDENCE OF DEC	EDENT						rick				Fr	eder	1CK	
DIRECTOR	Mary land	10b. COUNTY				TY, TOWN O								10d. INSIDE CITY LIMITS?	
	Maryland 100. STREET AND NUMBER	rrec	derick _		1 1	rede		ZIP COD	E I			100 CIT	IZEN OF	¹¾☐ YES 2 ☐ NO WHAT COUNTRY?	
FUNERAL	817 North	Marke	t Street	Apt.	В			217	01					States	
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. A	RMED	13.	WAS DEC	ENDENT C	OF HISPAN	NIC ORIGIN	? (Specify Yea		14. RAC	E — American Indian,	
	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: White												ellv:		
	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working													wnite	
COMPLETED	[Specify only ingrest grace completed] (Give kind of work done during most of working life. Do NOT use retired.) [Give kind of work done during most of working life. Do NOT use retired.]														
MP	10 Printer Newspaper														
BE	Edward H. Loiselle Catherine Loya														
2	Myrtle May	Hobbs	Loisell								Frede			21701	
	25s. METHOD OF DISPOSITI	iON n 3 □ Ramo	wel from State	20b. PLACI	E AND DATE	OF DISPOS	ITION /Ne	me of			20c. LO		_		
	4 Donation 5 Other		State in	Hage	remetory or c	n Cre	emat	ory		7/17/	/95 Ha	gers	town	, Maryland	
	I BIGHATORE OF FUNERAL	T) T)	. 1	11										Homes, P.A.	
	feet	110	May	cka	7						lke F			, MD 21702	
	23. PART i. Enter the di shock, or he	seases, or co part failure. L	omplications that list only one cau	t caused the d	m. Do	not entar	tha mo	da of dy	ing, suci	h as card	lac or respi	ratory ari	rest,	Approximate Interval Batween	
	IMMEDIATE CAUSE (Fin disease or condition	al		10.0	40	Co . 4.	(014)	Lek A.	Dar	Δ.	a.) a !	L (0	1.	Onset and Death	
	resulting in death)	8	DUE TO	(OR AS A CONS	EQUENCE O	F):	LWVE	ropic	COV	THE	ciaeu	(()	NU	dan	
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ATI	if any, leading to immed cause. Entar UNDERLY	liata	DUE TO	(OR AS A CONS	EOUENCE O	F):	•								
FIG	CAUSE (Disease or injust that initiated events		DUE TO	(OR AS A CONSI	EOUENCE O	F):									
CERTIFICATION	resulting in death) LAST	r L a	•												
-	PART ii. Othar significa	nt conditions	contributing to	daath but not	resulting	In the un	darlying	cause g	given in	Part i.	24a. WAS AN	AUTOPSY	248	. WERE AUTOPSY FINDINGS	
MEDICA				He	prot	eve	de		/		PERFOR		-	AVAILABLE PRIDR TO COMPLETION OF CAUSE	
								/				al.		DF DEATH?	
SICIAN:	DID TOBACCO US		IBUTE TO CA			ES 🔲 N		UNC	ERTAIN	V 🗆					
SICI	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:	SWITE-CO.	CE OF DEA	GTHER	t:	7							
PHYS	27. MANNER OF DEATH		1 Inputlant 2 I	INJURY	26b. TIM		28c. INJ		sidence	8 Other	(Specify) CRIBE HOW IN	NJURY OC	CUBED		
ВУ Р		Pending nvestigation	(Month, D	ay, Year)	IN.	JURY	1 🗌 Y	RK?	NO				301125		
E	4 Homicide determined Criy or rown, State)														
COMPLETED	(Check only		IAN: To the best of												
8	29b. SIGNATURE AND TITLE		: On the basis of a	xamination and/or	rinvestigatio	on, in my o	pinion, de				end place, and			a) and manner as stated,	
BE	290. SIGNATURE AND TITLE	Die	246	11	1	SV.			ENSE NUM	IBER		29d. DATI	HI-	(Month, Day, Year)	
5	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH (IT)	M 27) (Type	rint)		טע/	186				40	Ha	
	Dr. Philip	Shapir	o, 814 T	ollhous	e Ave	, F	rede	rick	, MI	217	01				
	31. DATE FILED (Month, Day,)	rbar)	32. REGISTRA	HIS SIGNATURE	Part 11	1				~/					
	JOF 7	1 1333	U		AL VALLE	7									



1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		TIEGIOTHAN				CE	LA CILL	CHIE	. Ur	DEA	i II		REG. NO.					
		1. DECEDENT'S NAME (First,	Middle, Last)									2. DATE O			-/	3. TIME OF DEATH		
		ROBERT	MAR	rin Lir	NE.							JUL	Y 21		.995	820 AM		
		4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE	(In yrs. last I	birtnday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF		1		LACE (State or Foreign		
		220-09-782	20	1 🔀 M 2 🗆 F	70			MONTHS	DAYS	HOURS	MIN.	(Month.	10,19	16	Country)	RYLAND		
should		9e. FACILITY NAME (If not ins		treet and number)				9h CITY	TOWN (OR LOCATI	ON OF DE		10,1.		NTY OF DEA			
ري به	Œ.				TIA T													
. 2,	СТОВ	WASHINGTON RESIDENCE OF DEC	EDENT	II nospi.	Į AL				HA	GERS'	TOWN			WA	SHIN	GTON		
Pages	DIRE	10e. STATE	10b. COUNTY	1			10c. CITY	, TOWN O	R LOCA	TION						10d. INSIDE CITY		
±:	0	MARYLAND	W	ASHINGTO	N.				KEE	DYSV	ILLE					LIMITS?		
permit.	AL	100. STREET AND NUMBER							10	1. ZIP COD	E			10g. CITI	ZEN OF WH	IAT COUNTRY?		
isi.	1 65	96 SOUTH M	IAIN S	TREET							2175	56	_		U.S.	Δ _		
020 physician. burial-transit	FUN	11. MARITAL STATUS		12. WAS DECEOEN	IT EVER	N U.S. ARM	ED	13. V	WAS DEC	CENDENT C	OF HISPAN	IIC ORIGIN?	(Specify Yes	or No—	14. RACE -	- American Indian		
	ВУ Б	1 Never Married 2 1 1 2 1 3 2 2 3 2 3 3 3 3 3 3 3 3 3 3		FORCES? 1)			ecify Cube		n, Puerto Ric	can, etc.)		Black, Specify:	White, etc.		
attending se as the														1	-,,-	WHITE		
	9	15. DECE (Specify only	EDENT'S EDUC highest grade	CATION completed)		18a. OECI	EDENT'S L	JSUAL OC	CUPATIO	ON ost of working	na	18b. K	IND OF BUS	INESS/IND	USTRY			
Z Z Z	LET	Elementary/Secondary (0-	-12)	College (1-4 or 5	+)	life. C	Do NOT use	retired.)										
the hospital or detached for u	₽	11					GRO	GROCER SELF-EMPLOYED							ED GR	OCERY STOR		
the hos detach		17. FATHER'S NAME (First, Mil								18. MOTI	HER'S NAI	ME (First, Mic	ddle, Maiden S	Surname)				
		ELMER ROY I	LINE							CAR	RIE	VIRGI	NIA S	NECKI	ENBER	GER		
retained by the 5 should be of notified at	5	190. INFORMANT'S NAME (Ty	rpe/Print)			19b.	MAILING A	ADDRESS	(Street	and Number	or Rural F	Route Number	City or Town	, State, Zip	Code)			
ay be re page 5		MARTIN R. LINE [16856 Petmar: Circle, Hagerstown, Marylar												d 21742				
		20s. METHOD OF DISPOSITION 1 Surfel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION / Name of Complete Comp																
5 6 E		ROSE HILL CEMETERY 7/24/95 HAGERSTOWN												WN,	MARYLAND			
		21. SIGNATURE OF FUNERAL SERVICE LIGHTSEE 22. NAME AND ADDRESS OF FACILITY 7.6.0.6.0.1.3. Nightings													mal Dilea			
		Dul	171-K	low	Paul	M. I	Dean	BAS	ST E	FUNER	RAL H	OME				21713		
urs after in by the removal.		23. PART I. Enter the dis		and the same of th	t ceuse	d the deel	th. Do no	ot enter i	the mo	de of dvi	no auct	ss cerdie	C Dr reenir	DOT O	, LID	Approximete		
	1 1	anock, or ne	eart tellure.	List only one ceu	iee Du e	ech line.			11/2		ing, ado	, do cordia	о в теери	albiy ell	oot,	Interval Between		
# 5 2	1 1														Onset and Death			
rted withings completely fille ial, cremation, event, the		resulting In death) e. Metalatic Colon Cancer Due To (DR AS A CONSEQUENCE OF):																
\$ 5 5 5 S																		
be be executed by the sician and confor to buring traumatic	CATION	Sequentially list conditions, If any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF):																
ficate be ophysician ne prior to		I stry, resuming to immediate																
	单	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):																
L & & - 0	1 1 1	resulting in death) LAST																
0 0		PART II. Other significer	nt condition	a contribution to	do oth h													
			7		Geeth D	out not res	suiting in	the unc	derlying	g ceuse g	given in i	Part I. 2	PERFORMED? AVAILABLE PRIOR TO					
uires that signed by Health an	ă		rnev.	nonia								1	1 □ YES 2 ■ NO OF DEATH?					
law requires that as been signed by lept, of Health an 23 shows any															1	☐ YES 2 ☐ NO		
AL FIR he law req has been b Dept. of n 23 she	Z	DID TOBACCO US	-	RIBUTE TO CA						UNC	ERTAIN	1 🗆						
V: The cate has State D		25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		26. PLACE		OTHER										
DR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate his ours after death with the State C tem 28 is marked, or item	YS	1 TYES 2 NO		1 Inpatient 2		_	DOA	4 - Nural	ing Hom	_	sidence	8 🗆 Other (Specify)					
This of the control o	РНҮ	27. MANNER OF DEATH 1 □ Natural 5 □ F	Pending	28a. DATE OF (Month, D	ley, Year)		28b. TIME INJU	OF IRY	WO	URY AT		28d. DESCR	RIBE HOW IN	JURY OCC	URED			
DING PHYS After this death with	B		nvestigation					M		YES 2	NO							
OR: A			Could not be	28e. PLACE O building,	atc. (Spec	— At home cify)	e, Jerm, st	reet, facto	ry, offic			28I. LOCATI City or	ION (Street er Town, State)	nd Number	or Rural Rou	te Number,		
L DR ATTENDING F DIRECTOR: After hours after death	MPLET																	
	립	(Check only	FYING PHYSIC	CIAN: To the beat of	my know	ledge, daati	h occurred	at the tin	ne, date	end placa,	and dua	to the cause	(s) end manr	ner es stale	ed.			
THE HOSPITAL THE FUNERAL I filed within 72 h PORTANT: If II	CON	one) 2 MEDIC	CAL EXAMINE	R: On the basis of a	xaminatio	n end/or Inv	reatigation	, in my op	inion, d	leath occur	ed at the l	lime, data er	nd place, end	due to the	ceuse(s) a	ind menner es stated.		
E HO	Ш	29b. SIGNATURE AND TITLE	OF CERTIFIER								NSE NUM			29d. DATE	SIGNED (M	fonth, Day, Yesr)		
TO THE HOSPIT TO THE FUNERA be filed within 7	B	muchael	1. "	melon	ach	- /	m.1	2.		0	141	667		•	7.21	1.95		
	2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DE	ATH (ITEM :	27) (Type, I	Print)										
		Michael J	. Me	Cornack		1790	9 10	buc	-11	Ro	ad	ME	serst	2000	. Mi	0. 21740		
		31. DATE FILED (Month, Day 3	15 1/2	HEOR HA	ers blok	totle			-/-		- 1		/		<i>r</i>	0. 21740		
		JUL 4 4 193	0-	o wasani														



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

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	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /	/ DEPARTMENT OF ERTIFICATE OF	HEALTH AND	MENTAL HYGIEN							
SE COMPLETED BY FUNERAL DIRECTOR	0 51 2. 7	5. SEX 6. AGE (In yrs. le:		2. DATE OF DEATH MONTH D. D. D. D. D. D. D. D. D. D. D. D. D.	3. TIME OF DEATH OHZO M MITHPLACE (State or Foreign Unity) F DEATH ACLUMCE I							
	MO Ance 100. STREET AND NUMBER 570 Bellet	Arundel rive Drive		10g. CITIZEN OF WHAT COUNTR								
	1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDUCA (Specify only highest grade oc	1 Never Married 2 Married FORCES? 1 YES 2 NO If YES, GIVE WAR OR DATES 1 Never Married 2 Married FORCES? 1 YES 2 NO If YES, GIVE WAR OR DATES 1 YES, GIVE WAR OR DATES 1 YES 2 NO Specify 1 YES 2 NO SPECIFIED NO SPECIFUL NO SPECIFUL NO SPECIFUL										
	8 17. FATHER'S NAME (First, Middle, Last) Gabino Se	1.1	lome make		ME (First, Middle, Maiden	Sumame)						
TO B	196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 197. Manager State 198. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 198. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 199. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209. PLACEAND DATE of DISPOSITION (Name of Campeter) Control of Campeter, Cremetory or Town, State, Zip Code) 209. PLACEAND DATE of DISPOSITION (Name of Campeter) Control of Campeter, Cremetory or Town, State, Zip Code) 209. PLACEAND DATE of DISPOSITION (Name of Campeter) Control of Campeter, Cremetory Control of Campeter, Cremetory Control of Campeter, Ca											
CERTIFICATION	23. PART J. Enter the diseases, or co shock, or heart feliure. Li iMMEDIATE CAUSE (Finei disease or condition resulting in death) a. Sequentially list conditions,	Approximate Interval Between Onset and Death										
	if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	OUE TO (OR AS A CONSEC										
MEDICAL	PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. Left hip fracture, lakinson's history Alzhamer's history DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO NOTE UNCERTAIN											
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTMES.										
B≼	27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation 3 Suictide 8 Could not be detarmined	289. OATE OF INJURY (Month, Day, Year) 1	M 1	JURY AT ORK? YES 2 NO	28d. DESCRIBE NOW INJURY OCCURED Location (Street and Number or Rural Route Number, City or Town, State)							
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER											
H	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)											

STEVENSVILLE

MD

21666

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

HARMS MO JAMIE MAIN ST 102

31. DATE FILEO (Month, Day, Year)

JUL 20 1995 32. REGISTRAR'S SIGNATURE

1 - STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)
PAUL ROLAND MILLER

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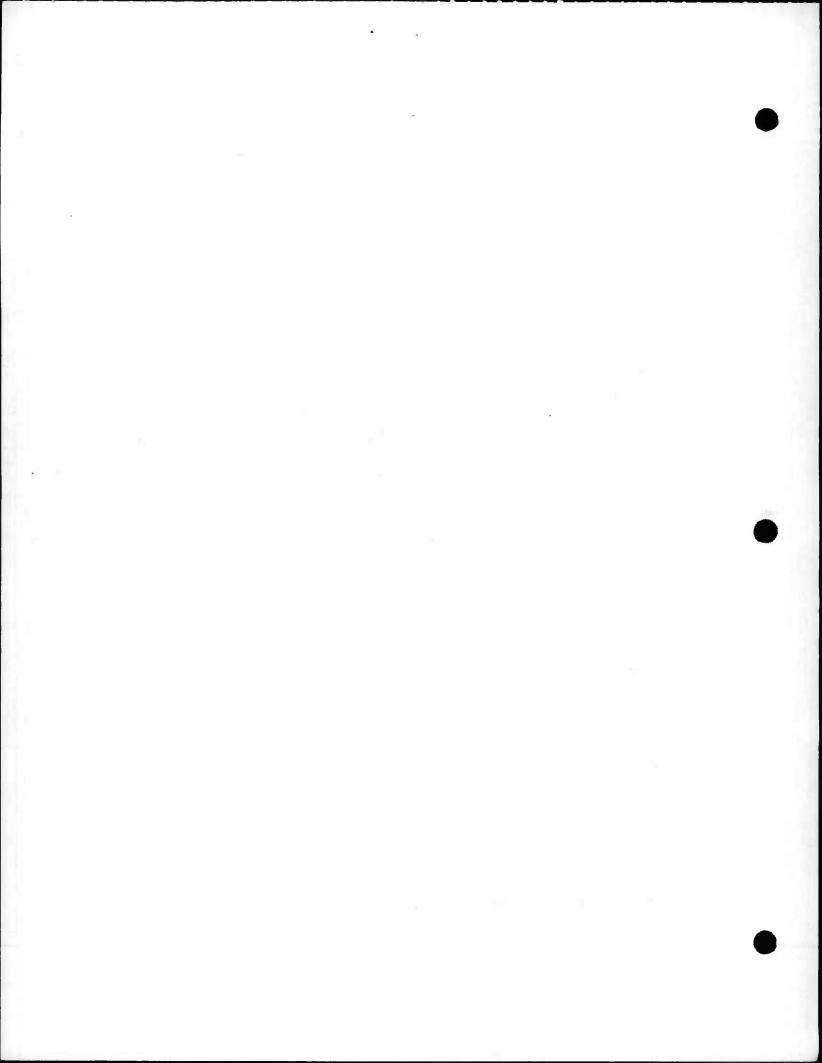
			LAND	MILLER							2. DATE OF MONTH July	DAY	1995	YEAR	3. TIME OF DEATH 0030 a
pino	ECTOR	4. SOCIAL SECURITY NUMBER 213-24-58.	28	5. SEX 1 X M 2 F	6. AGE (In yrs. las	YRS.		DAYS	IF UNDER 2	MIN.	7. DATE OF 1 (Month, Da Feb 2	8', 1	929	Penn	LACE (State or Foreign isylvania
1, 2, 3 should		96. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL 96. COUNTY OF DEATH Cumberland 96. COUNTY OF DEATH Allegany								ath 1y					
permit. Pages 1	DIR	10a. STATE PA	10b. COUNT						***					10d. INSIDE CITY LIMITS? 1XXYES 2 \(\backsquare \) NO	
isi	TO BE COMPLETED BY FUNERAL	P. O. BO	TAND NUMBER O. Box 83				101	ZIP CODE	64		10g. CITIZEN OF WHAT COUNTRY? USA				
215-0020 attending physician. se as the burial-transit		11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR D			YES 2 X	3 2 NO If yes, specify Cuben, Mexic			HISPAN Mexicen Specify:	, Puerto Rica	pecify Yee o	or No— 14	14. RACE — American Indian, Black, White, etc. Specify: White		
1215 r attend use as			EDENT'S EDU highest grade		(G	ive kind of w	USUAL OCC	UPATIC	N st of working		16b. KIN	O OF BUSI	NESS/INDUS		LE
YLAND 21. by the hospital or be detached for u at once.		Elementery/Secondary (0		College (1-4 or 5	+) life.	. Do NOT use	ng cl		_		3	Tire 1	nanuf	actu	ıring
MARYLAND 212- retained by the hospital or att 5 should be detached for use notified at once.		17. FATHER'S NAME (First, M George	Miller						La	aura	Werne	er			
E, MAR be retained age 5 should		Doris D.	Mille		191	P. O	Box	Street a	we.	or Aural A ller	sburg	PA	State, Zip C. 15564	ode)	
ALTIMORE, death. Page 6 may be funeral director, page		20s METHOD OF DISPOSITE 142 Burlel 2 Crematio 4 Donation 5 Other	(Specify)		206. PLACE A cometery, cre Green	MODATEO	e Cem	ete	ry	7/19			ntion – cm envił		
BALTIMORE, MARYLAND 21215-0020 ter death. Page 6 may be retained by the hospital or attending physic the funeral director, page 5 should be detached for use as the burial pal. examiner must be notified at once.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Harvey H. Zeigler Funeral Home Hyndman, PA 15545-0636													
in 24 hours at ely filled in by nation, or remo	IMMEDIA disease of resulting NO Sequential if any, let cause. Et CAUSE (It that initial	23. PART I. Enter the lishock, or his immediate CAUSE (Find disease or condition resulting in death)	sert tellure.	Meta	static	sma	11 c				ss cardisc	or respire	tory arres	st,	Approximats Interval Between Onset and Deati UNKNOWN
687 xecuted and con burial, tatic er		Sequentially list conditi		OUE TO (OR AS A CONSEQUENCE OF): U DUE TO (OR AS A CONSEQUENCE OF):							unknowr				
certificate nding physic Hygiene pri		cause. Enter UNDERLYi CAUSE (Disease or inju that initiated events resulting in deeth) LAS	η 1	C DUE TO (OR AS A CONSEQUENCE OF):											
RDS, P nat the death by the atten and Mental H		PART II. Other significe	nt condition	s contributing to	deeth but not re	esuiting in	the unde	riying	ceuse gi	ven in F	art i. 24s	. WAS AN A		24b. V	VERE AUTOPSY FINDINGS
RECORDS, F we requires that the death is been signed by the atter ppt. of Health and Mental 3 shows any Injury, or	MEDICAL							1000			PERFORM YES 2	2 X NO CO		WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
- # # P N		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒													
VITAL FAN: The law ficate has be State Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO	MEDICAL	HOSPITAL:			OTHER:			Idamas 0					
ON OF VITA ING PHYSICIAN: The After this certificate his the State C marked, or Item	ВУ РНУ	27. MANNER DF DEATH 1 ☑ Netural 5 ☐ 1	77. MANNER DF DEATH 28e. DATE OF INJURY (Month, Day, Year)				28b. TIME OF 28c. INJURY AT WORK? M 1 YES 2 NO				28d. DE\$CRIBE HOW INJURY OCCURED				
TTEND TTOR: A after d	ETED B	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, etreel, fectory, building, etc. (Specify)				, office	Office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
DIV PITAL OR A ERAL DIREC In 72 hours	COMPLE	29e. CERTIFIER (Check only one) 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the ilme, date and place, and due to the cause(s) end menner as stated. 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner as stated.													
TO THE HOSPITAL (TO THE FUNERAL C Be filed within 72 h IMPORTANT: If it	BE	1. M. Carller M.				29c. LICENSE NUI D 4 4 7			SE NUME				E SIGNED (Month, Day, Year) July 17, 1995		
12	5	N. McCul	lough	, MD, 9	902 Set	on D	Print) Orive	,	Cumb	erl	and,	MD 2	21502	2	
		31. DATE FILED (Month, Day, 1)		La Lau	R'S SIGNATURE	all					_			-	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

4,17

	30	4. SOCIAL SECURITY NUMBER 218-16-9333	The second secon	(In yrs. last birthday)		1	2. DATE OF DE MONTH JULY 2. DATE OF BIR (MONTH) Day 1	5, 1995	B. BIRTHPLACE (State or Foreign			
2, 3 should	TOR	90. FACILITY NAME (If not institution, give st 26541 Possum H	treet and number)	U THS.		N OR LOCATION OF DI	EATH	9c. COUNT	Maryland Y OF DEATH Coline			
nit. Pages 1,	DIRECTOR	10e. STATE 10b. COUNTY Maryland	Caroline		TY, TOWN OR LO	alsburg			10d. INSIDE CITY LIMITS? X 1 YES 2 NO			
in. ransit permit.	FUNERAL	26541 Possum	Hill Road	1			.632	U.S.	en of what country?			
5-0020 nding physician. is the burial-fransit	BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 TYES IF YES, GIVE WAR OR D	2 XNO	If yes,	ecendent of Hispai specify Cuben, Mexico ES 2 MD Specifi	n, Puerto Ricen, e	offy Yee or No— 1.	4. RACE — American Indian, Black, White, etc. Specify: White			
zal or atte	PLETED	15. DECEDENT'S EDUC (Specify only highest grade) Elementary/Secondary (0-12) 1.2		16a. DECEDENT'S (Give kind of life. Do NOT life. Taring		TION most of working		of Business/INDU				
8 6 A	BE COMPL		redith			Lilli	ME (First, Middle, I e Scot	Maiden Sumame) ct Merec	dith			
ay be retained page 5 should be notified	5		edith	Вох	26808		Route Number, City	or Town, State, Zip C	eralsburg,Md			
e 6 m rector,		20a. METHOD OF DISPOSITION 10 Buriel 2 Cremetion 3 Remote 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE ALC.	oval from State Cer	b. PLACE AND DATE metary, crematory or Concor	d Ceme	tery 7	7/8/95		deralsburg,M			
BAL IIN ter death, Pag the funeral di oval. al examiner			awkin	5					n St., Federalsburg			
within 24 hours operation of the medical medic		23. PART I. Enter the diseases, or centre of the course of	List only die ceuse die	each line.	id 1.	node of dying, auc			Approximate Interval Between Onset and Death			
certificate be executing physician and lygiene prior to burn other traumatte	RTIFICATION	Sequentielly list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		A CONSEQUENCE (
the death the atter d Mental	핑	PART II. Other eignificant condition		but not resulting	In the underly	ing ceuse given in		Interval Between Onset and De 3				
requires that requires that seen signed by of Health an	MEDICAL	Enghes					_ 10'		ORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE			
- 6 -: "	SICIAN:	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE DF DE			N 🗆					
PHYSICIAN: The law this certificate has t with the State Dept rked, or item 23	PHYSI	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	1 Inpatient 2 ER/Out 28e. DATE OF INJURY (Month, Day, Yeer)	28b. TII	4 Nursing He	NJURY AT		how injury occur	RED			
L DR ATTENDING PHYSICIAN: The law L DIRECTOR: After this certificate has i hours after death with the State Depr liem 28 Is marked, or item 23	ED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Spe	Y — At home, ferm,		YES 2 NO	28f. LOCATION (City or Town,	Street and Number or State)	Rural Route Number,			
8 8 5 5	COMPLET		CIAN: To the best of my known:						ceuse(e) end menner ee stated.			
TO THE HOSPITAL IT TO THE FUNERAL DE filed within 72 he IMPORTANT; IT IN	TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	1 Com	D'Thoma		29c. LICENSE NUN	ABER 58	29d. DATE 5	SIGNED (Month, Day, Year)			
		30. NAME AND ADDRESS OF PERSON WHO	., Federal	lsburg,		1632			,			
		JUL 1 0 1995	82 REGISTRAR'S SIGN	Mardall								

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Ardella 0850 Major p. M July 995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign Country) 218-34-8600 1 🗌 M 2 🔯 F DAYE HOURS 58 VDC Jan. 16,1937 Maryland 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH Dorchester General Hospital DIRECTOR Cambridge Dorchester Pages 1, 2, RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Dorchester Cambridge 1 ₹ YES 2 NO permit. 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 10 Patamoke Way 21613 USA BALTIMORE, MARYLAND 21215-0020 hours after death. Page 6 may be retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 1 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—if yee, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES В 3 Widowed 4 Divorced **Black** COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 9 Nurse-Assistant State Institution once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Sumeme) te Hank Major 品 Viola Cornish notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Kirk Major Patamoke Way Cambridge, Maryland 10 ě 20a. METHOD OF DISPOSITION
1 □ Buriel 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must tery, crematory or other place) Bethel Cemetery □ Donation 5 □ Other (Specify) 7/21 Cambridge, Maryland examiner 21 SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Henry Funeral Home 510 Washington St. Cambridge, Maryland completely filled in by the medicai 23. PART Enter the diseases, or complications that caused the wisth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 0 IMMEDIATE CAUSE (Final Onset and Death the disease or condition neunwerms traumatic event, reaulting in death) Olie Well executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): Disence burial, CERTIFICATION TRUE WEG and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) Hygiene prior to signed by the attending physician and Health and Mental Hygiene prior to if any, leading to immediate cause. Enter UNDERLYING other t CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? PERFORMED? any 1 YES 2 NO Shows 1 YES 2 HO PHYSICIAN: certificate has been the State Dept. of or Item 23 si DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER:
4 Nursing Nome 5 Residence 6 Other (Specify) HOSPITAL OR ATTENDING PHYSICIAN: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? this c 28d. DESCRIBE NOW INJURY OCCURED marked, 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death vitem 28 is mark BY 2 Accident Investigation 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Nomicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE DE filed within 72 hours at IMPORTANT; If Item 21 COMPLET 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end menner ee stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and menner ee stated. 29h SIGNATURE ND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Yeer) BE

400 Aurora

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Cambridge, MD

Street

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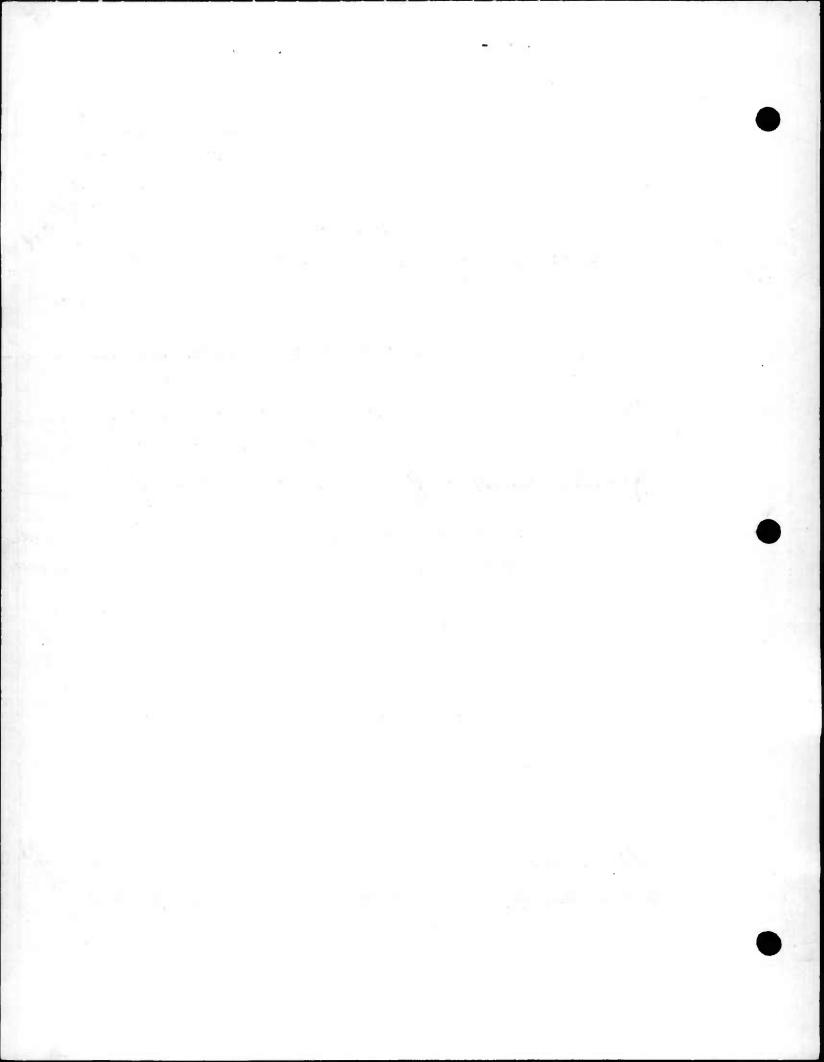
9 1995

Vinodrai Mehta, M.D.

31. DATE FILED (Month, Day, Year)

36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE Talia Struction Rawfall 21613



Pages 1, 2, 3 should

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR : 48PM 95 Barry L. Michelone 7 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 159-38-5880 1300M 2 | F 38 2/18/57 PA 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Atlantic General Hospital Berlin Worcester RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Blair PA Duncansville 1X YES 2 NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 16635 208 Sharon St. USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexican, Puerto Rican, atc.)

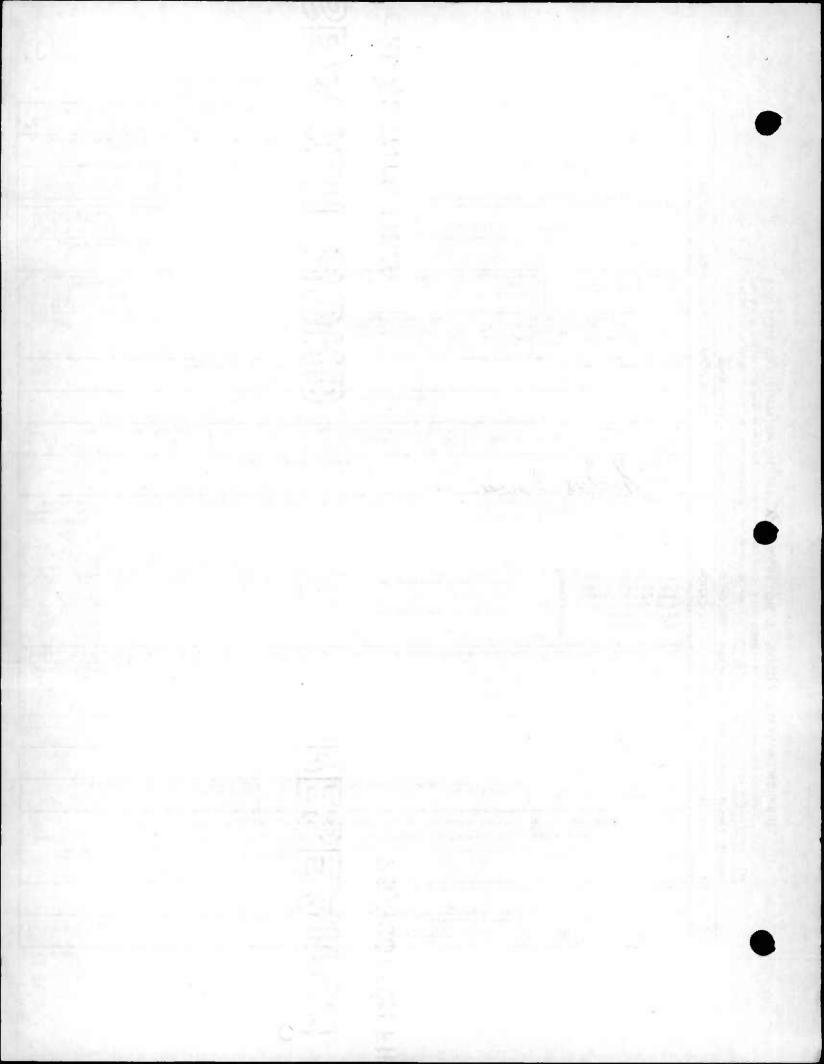
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BY 3 Widowed 4 Divorced white ED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY (Specify only highe E College (1-4 or 5+) Elementary/Secondary (0-12) COMPL Principal Education 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surneme) Theodore Michelone 76 Barbara L. Marick BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 208 Sharon St. Duncansville, PA Bernadette Michelone ě 20e. METNOD OF DISPOSITION
1X Burlel 2 Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must St. Joseph's Cemetery 7/17/9\$ Williamsburg, PA 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home >WX 108 Williams St. Berlin, MD Or nemoval the medical at caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, Approximate sert failure. List only one shock or h Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition rupture SPIENIC resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to burial, CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Mental shows any Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL Health and AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 12/4ction 1 YES 2 NO 1 YES 2 NO ō PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATN (Check only one) State HOSPITAL:
1 Dippetient 2 ER/Outpetient 3 DOA OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 TES 2 NO marked, or the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED With 1 Natural
2 Accident 5 Pending Investigation 1 YES 2 NO BY death 28e. PLACE OF INJURY — At home, farm, atreet, fectory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 69 6 Could not be determined COMPLETED after 4 Homicide 28 hours a Hell 29e. CERTIFIER
1 SCENTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated. TO THE HOSPITAL TO THE FUNERAL IS be filed within 72 h 2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(s) end manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 1441283 12

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ROBERT 4733 DU

34 REGISTRAR'S SIGNATURE

This Davidson Ke



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within after death. Page 6 may be retained by the hospital or attending physician.

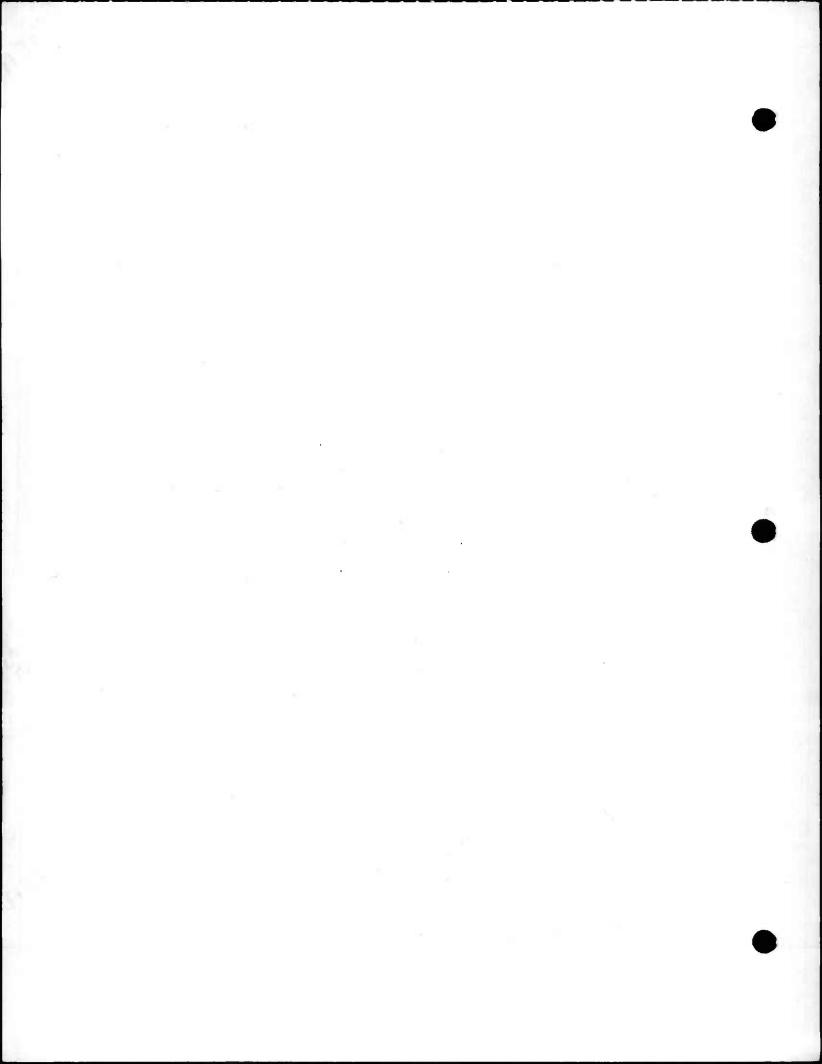
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 fours after death. Page 6 may be retained by the hospital or attending physician. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR

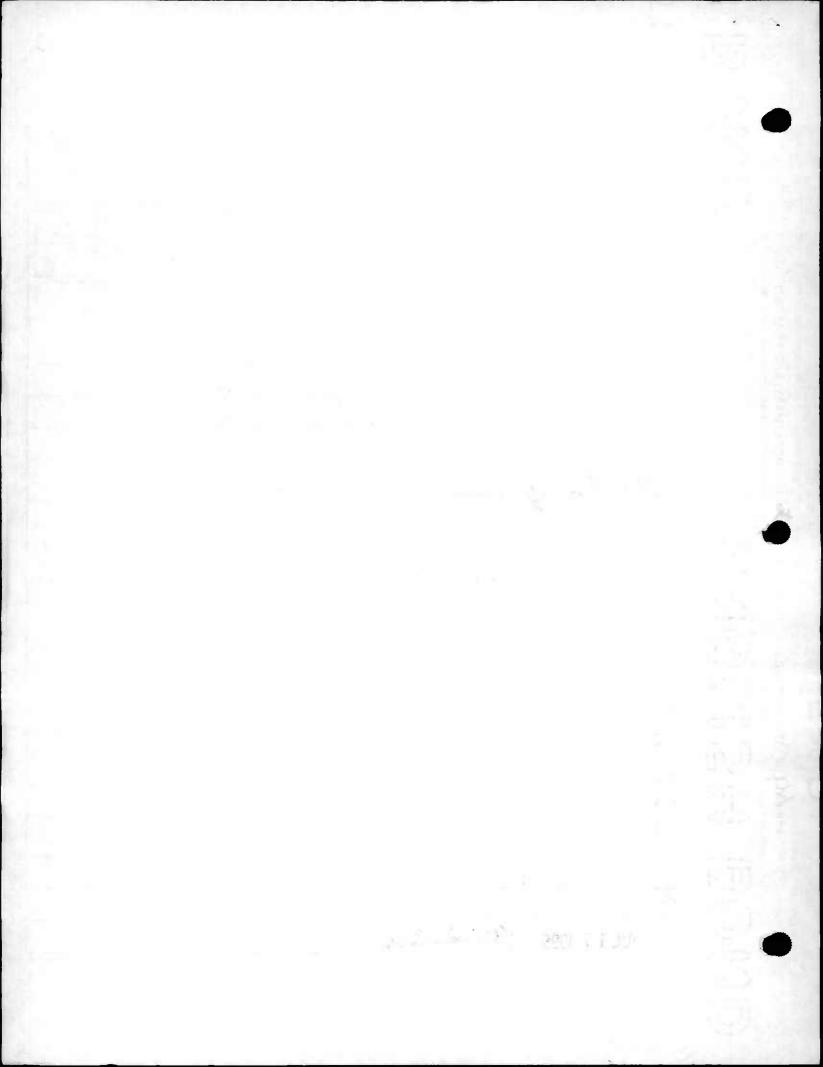
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	CATE OF	DEATH	REG. NO		
	1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	-	3. TIME OF DEATH
	CATHERINE CARE	R MERSCH	H			JULY 17,	1995 YEAR	3:10 0
			yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	A RIP	THPLACE (State or Foreign
		□ M 2 ⊠ F 96	S YRS.	MONTHS DAYS	HOURS MIN.	NOV. 5, 1	898 WAY	SHINGTON, D.C
_	9a. FACILITY NAME (If not institution, give street				OR LOCATION OF O	EATH	9c. COUNTY OF	
DIRECTOR	ST. CATHERINE'S NU	RSING CENTE	ER	EMMITS	BURG		FREDER	ICK
្រូ	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		I do dom	, TOWN OR LOCA				
Ē		OV			IIION			10d. INSIDE CITY LIMITS?
	MARYLAND FREDER I	.CK	IHU	RMONT				1 X YES 2 NO
FUNERAL	30 ALTAMONT AVE.			1	21788		U.S.A	WHAT COUNTRY?
3	11. MARITAL STATUS 12.	WAS DECEDENT EVER IN U	U.S. ARMEO	13. WAS DE	CENDENT OF HISPAN	NIC ORIGIN? (Specify Yes	or No- 14. R/	ICE - American Indian,
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	ES XNO	If yes, a	pecify Cuban, Maxica S 2 NO Specif	in, Puarto Rican, etc.)	Spe	ecify:
G	15. DECEDENT'S EDUCATION (Specify only highest grade com.	ON pleted)	16a. OECEDENT'S	USUAL OCCUPAT	ON ost of working	16b. KIND OF BU	WHI:	
COMPLET	Elementary/Secondary (0-12)	oilege (1-4 or 5+)	life. Do NOT use	ork done during m e retired.)	oat or worning			
₽	12		HOMEM	AKER		Non	ie	
8	17. FATHER'S NAME (First, Middle, Last)	0.177				ME (First, Middle, Maiden	Surname)	
BE	PATRICK JOSEPH	CARR			CATHER			POORE
욘	19a. INFORMANT'S NAME (Type/Print)	7.7.				Aoute Number, City or Tow		
	BARBARA FITZPATRIC					RHILL, N.H		
	20a. METHOD OF DISPOSITION 1/\(\hat{\Lambda}\) Burlai 2 \(\hat{\Lambda}\) Cremation 3 \(\hat{\Lambda}\) Removal	from State comet	ery, cremetory or off	has alacal			CATION — City or	
	4 Donation 5 Other (Specify)		OLIVET		RY ND ADDRESS OF FA	7/20 WAS	HINGTON	, D.C.
				ROBER	T E. DAI	LEY & SON,	P.A.	
ш	11/12			615 E	. MAIN S	T., THURMO	NT, MD	21788
	23. PART I. Enter the diseases, or compehock, or heart fellure. Liet	plicetions that ceused t	the death. Do n	ot enter the m	ode of dying, auc	h as cerdlec or respi	iratory erreet,	Approximete
	IMMEDIATE CAUSE (Fine)	any one ceuse on eed	- //		P 1			interval Between Onset and Deeth
	disease or condition resulting in death)	ancest	we He	Court	Tallen	1		1 WEEK
	7	DUE TO OR AS A C	ONSEQUENCE OF	- 1/	0 1	۸.		OVER 10
Z	Sequentielly list conditions,	Meiose	levot	E A	east,	Justan	e	YEARS
CERTIFICATION	If any, leading to immediate ceuse. Enter UNDERLYING	DUE TO (OR AS A C	ONSEQUENCE OF					
길	CAUSE (Diseese or injury	DUE TO (OR AS A C	OMOCOURNOS ON					
Ē	thet initieted events resulting in deeth) LAST	DOE TO TON AS A C	ONSEQUENCE OF	75				8
	PART II Other significant conditions co	ntributing to death but	not resulting in	the underlyin	g cause given in	Part I. 24s. WAS AN		Ib. WERE AUTOPSY FINDINGS
EDICAL	alzheimer	is Dise	me			PERFOR	100	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEC	Chronic Ole	structu	e lun	1 Diss	ease.		2,110	OF DEATH?
	DID TOBACCO USE CONTRIBU					vП		1 YES 2 NO
¥	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH	×				
Sic		DSPITAL: Inpetient 2 ER/Outpeti		OTHER:	ne 5 🗆 Residence	A CT Other Mineral		
PHYSICIAN	27. MANNER OF DEATH	26s. DATE OF INJURY	28th. TIME	OF 28c, IN	JURY AT	28d. DESCRIBE HOW II	NJURY OCCURED	
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Morth, Day, War)	INJU	111 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	YES 2 NO			
	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY -		reet, factory, offic	• 0	28f. LOCATION /Street a	and Number or Russ	Floure Number
COMPLETED	4 Homicide determined	building, etc. (Specify)	9.			City or Yown, State)		
۳	29a. CERTIFIER 1 CERTIFYING PHYSICIAN	: To the best of my knowled	for death consum.	4 44 45 - 41 4-4				
M	(Check only one) 2 MEDICAL EXAMPLER: Or							(a) and manages at its 4
	29b. SIGNATURE AND TITLE OF CENTIFIES							
BE	The second one and the or dening	1 () A	1111	1 MA	29c. LICENSE NUN	ABER O	29d. OATE SIGNE	D (Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO CO	MPI FTED CAUSE OF DEAT	H (ITEH 27) CT	Orine	D10	103		10170
					CRIIDO M	ת 21727		
	ALAN L. CARROLL, M	32. REGISTRAR STEIGHT	URE A	, EURILI	SDUNG, M	D. ZI/Z/		
	31. DATE FILED JUL 201 1995	32. REGIS/RAR SISIGNAT	ionharball	R				



STATE	0F	MARYLAND	/ DEPAR	TMENT	0F	HEALTH	AND	MENTAL	HYG	ENE
			ERTIF	CATE	OF	DEAT	H		REG.	NO.

	1. DECEDENT'S NAME (First									2. DATE OF MONTH	DEATH	γ	YEAR	3. TIME OF DEATH
			retta Me	rrim	an			_		July	14,	1995) LAN	6:45 A M
	4. SOCIAL SECURITY NUM		5. SEX		n yrs. last birth	MONTH	DER 1 YEAR	IF UNDER	24 HRS.	7. DATE OF (Month, De	BIRTH ly, Year)		8. BIRTI	IPLACE (State or Foreign
	218-24-1708		1 🗌 M 2 💢 F	7	6 ^v	RS.				(Month, Di 11/13	<u>3/18</u>			yland
-	9e. FACILITY NAME (If not in	All Parkets						OR LOCATI	ON OF DE	EATH		000 000	NTY OF E	
2	18832 Sand		Road			K	noxy	ille				Was	hing	ton
1	10a. STATE	10h. COUNT	1		100	. CITY, TOWI	N OR LOC	ATION						10d. INSIDE CITY
5	Maryland	Frede	rick			Bruns	wick							1 X YES 2 NO
1	10e. STREET AND NUMBER							of, ZIP COO	E			10g. CIT	IZEN OF	WNAT COUNTRY?
FUNERAL DIRECTOR	1100 Peach	0rcha	ard Lane					217	16				USA	
5	11. MARITAL STATUS 1 Never Merried 2	Mandad	12. WAS DECEDER FORCES?	T EVER IN	U.S. ARMED	1				NIC ORIGIN? (S in, Puerto Rice		or No—	14. RAC Blac	E — American Indien, k, White, etc.
5	3 (X) Widowed 4 Dive		IF YES, GIVE	MAR OR DA	TES			S 2 NO					Spec	White
	15. DEC	EDENT'S EDU	CATION	Т	16e. DECEDE	NT'S USUAL	OCCUPAT	TION	-	18b. K/l	ND OF BUS	INESS/IN	DUSTRY	WIII CE
COMPLEIED	(Specify on Elementary/Secondary (I	y highest grade 0-12)	College (1-4 or 5	+)	(Give kin	d of work do IOT use retired	ne during n d.)	nost of worki	ng					
	8				Cook					Res	staur	ant		
١ {	17. FATHER'S NAME (First, M						П			ME (First, Midd				
20	Albert N. Deaner Florence V. Kelbaugh													
5	19a. INFORMANT'S NAME (Type/Print) Gene Tribby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 3, Box 1280 - Harpers Ferry, WV											,	5405	
٦.	Gene Trib) - F		_			
	20a. METHOD OF DISPOSIT	on 3 🗌 Rem	oval from State	of c	PLACE ANO	OATE OF DI	spositio	N (Name	-0007	7/17			-	own, State
	4 Donation 5 Other		CENSEE		DI OWI ISV	1 2	2. NAME	ights Cemetery 7/17 Brownsville, MD						טויו ,
	· P. I	11	P				Eack	les-S	pend	er Fur	neral	Hom	ie	
4	23. PART i. Entar tha	1 1-	Spira							/, WV 2				
CEMINICATION	immediate cause (Fi disease or condition resulting in death) Sequentially list condition if any, leading to immediate. Enter UNDERLY CAUSE (Disease or injust) that initiated events	tions, ediata	e. Paly	(OR AS A	CONSEQUEN	CE OF):	Se.)							Onset and Death Yellus Yellus
	reaulting in death) LAS	ST	d											
	PART II. Other signific	ant condition	ns contributing to	daath b	ut not resui	ting in the	underlyi	ing cause	given in	Part i. 24	a. WAS AN	AUTOPSY	24	b. WERE AUTOPSY FINDINGS
FUICAL											PERFOR	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MED										_ '	☐ TES 2	A NO		OF DEATH? 1 YES 2 NO
-										_				
HYSICIAN	25. WAS CASE REFERRED	TO MEDICAL					26.	PLACE OF I	DEATH (C	neck only one)				
2	EXAMINER?		HOSPITAL:	☐ ER/Outp	etlent 3 🗆 D	OTH	IER: Nursing Ho	ome 5 X R	esidence	8 Other (S	Specify)			
ву Рну	27. MANNER OF DEATH 1 Netural 5 2 Accident	Pending Investigation	28a. DATE O (Month,	F INJURY Day, Year)	26	b. TIME OF INJURY	V	NJURY AT WORK? YES 2] NO	26d. OEŞCR	IBE HOW	NJURY O	CCURED	
3	2 Culates	Could not be determined		OF INJURY I, atc. (Spec	Al home, 1	larm, street, 1	factory, of	fice			ON (Street lown, State)		er or Rural	Route Number,
COMPLE	Torroom ormy		ICIAN: To the best of											(a) end manner ee steted.
IO BE	SE NAME AND ADDRESS O	MAR	lump	ISE OF OF	ATU (ITEM 27)	(See Brief)		29c, LIC	2 2	MBER		29d. DA	TE SIGNE	(Month, Day, Year)
ij	Lloyd E. H	alvors	on. M. D	_ 1	475 Ta	anev A	Avenu	ue -	Fred	erick,	MD 2	21702	2	
	31. DATE FILED (Month, Day	1 7 195	35 Jah	A dollar	ATURE CA	rall								



	_	FOR STATE REGISTRAR		STATE OF I	MARYLAN	ID / DEPAR	TMENT ICATE	OF H	EALTH DEA	AND N	MENTA	L HYGIE				
		1. DECEDENT'S NAME (First, Mid	Idle, Last) E	IELY.	N.	MILE	S				2. DAT	E OF DEATH	13 /	995	3. TIME OF DEATH	
P		4. SOCIAL SECURITY NUMBER 215-36-4058 M	1 (SEX	6. AGE (In)	rrs. lest birthdey) YRS.	IF UNDER 1	YEAR DAYS	IF UNDER	R 24 HRS. MIN.	7. DATE (Mon API	OF BIRTH (th) Day, Year) RIL 3	1913	6. BIRTHI Country WAS	PLACE (State or Foreign	
1, 2, 3 should	TOR	90. FACILITY NAME (If not institute VILLA ST. MIC RESIDENCE OF DECED	HAEL N		HOME				OR LOCATI	ION OF DE	ATH			TIMOI		
permit, Pages	DIRECTOR	MARYLAND 106	CHARL	ES			y, town of RBURY		TON						10d. INSIDE CITY LIMITS? 1 Tes 2 K NO	
	FUNERAL	100. STREET AND NUMBER CHICAMUXEN RO.						101	. ZIP COD 2065					ED S	HAT COUNTRY?	
5-0020 ding physician. the burial-transit	ВУ	11. MARITAL STATUS 1 Never Married 2 Meri \$\frac{1}{X}\text{ Widowed 4 Divorced}	ried	WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES :	2 K NO	It	yes, spi	ecity Cubi		, Puerto	N7 (Specify 1 Ricen, etc.)	es or No—		- American Indian, White, etc.	
MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the bunal notified at once.	PLETED	(Specify only high Elementary/Secondary (0-12)		ON pleted) plege (1-4 or 5		Give kind of a life. Do NOT us	work done du se retired.)	UPATIC ring mos	ON st of working	ing	16	b. KIND OF B		DUSTRY	DIATOR	
YLAND of the hospital by the hospital be detached for all once.	E COMPL	10TH GRADE 17. FATHER'S NAME (First, Middle, FRANK THOMAS	, Last)			HOME M	AKEK					PRIVA Middle, Maidl THOMAS	n Surname)	KS		
be retained to 5 should e notified	TO BE							Street e	nd Number	r or Rural Ro	oute Nun	nber, City or T	own, State, Zi	Code)	1D. 20743	
ORE 6 may ector, pa		16e INFORMANT'S NAME (Total)													n, State MARYLAND	
~ _ = =		Budge C.	2hle	ti N JOHN	SON MO	00583	TH	ORN	TON	FUNE:	RAL	HOME,			AD, MD.2064	
hours afted in by or reme		23. PART I. Enter the diseer ahock, or heart iMMEDIATE CAUSE (Fine) disease or condition	ses, or comp feliure. List	only one ceu	ise on eech	ilne.	ot enter ti	ne mod	de of dy	ing, such	es cer	diac or res	piratory ar	rest,	Approximate interval Between Onset and Death	
executed within 24 and completely fills to burial, cremation matic event, the	Z	disease or condition resulting in death) e. CONCTESTIVE HEART FAILURE DUE TO (DR AS A CONSEQUENCE OF): Sequentially list conditions. b. HEUTE MYOLARDIAL DIREARCTON												Kmin		
O. BOX certificate be ing physician ygiene prior to other traus	RTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST				PHSEQUENCE OF	F):					III VI				
ORDS, P that the death led by the atten th and Mental H any injury, or	MEDICAL CEF	PART II. Other significent of	4	ntributing to			n the und		couse (given in P	Part i.	24a. WAS A PERFO	A AUTOPSY AMAILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH?			
AL RE le law requi has been s Dept. of H	IAN: ME	DID TOBACCO USE (ЛЕ ТО СА		DEATH YE			UNC	ERTAIN					1 YES 2 M8	
ICIAN: The Servificate the State	PHYSICIAN:	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH		SPITAL: Inpatient 2 -	ER/Outpetle	nt 3 DOA	OTHER:				_	н (Specily) SCRIBE HOW	INJURY OC	CURED		
After death	ED BY P	3 Suicide 8 Could	tigation is not be	(Month, Di		At home, term, a	М		ES 2	NO	28f. LOC	CATION (Street or Town, State	t and Number		ute Number,	
# No # 1	PLET	290. CERTIFIER CERTIFYIN	Mined			e, death occurre	d at the time	, date	end place,	, end due to				led.		
TO THE HOSPITAL TO THE FUNERAL De filed within 72	BE COMI	2 MEDICAL		the beels of ex	camination en	d/or Investigation	n, in my opi	nion, de		red at the ti		end plece,	_		Month, Pay, Year)	
5 5 3 8	5	M. MAME AND ADDRESS OF PER	ISON WHO COI	MPLETED CAUS	E DE DEATH	(ITEM 27) (Type	Print)	Щ	1) 28	591	5	1 1 211	1	7/1	4/95	

(ITEM 27) (Type, Print)

Julia Skvidson Randall

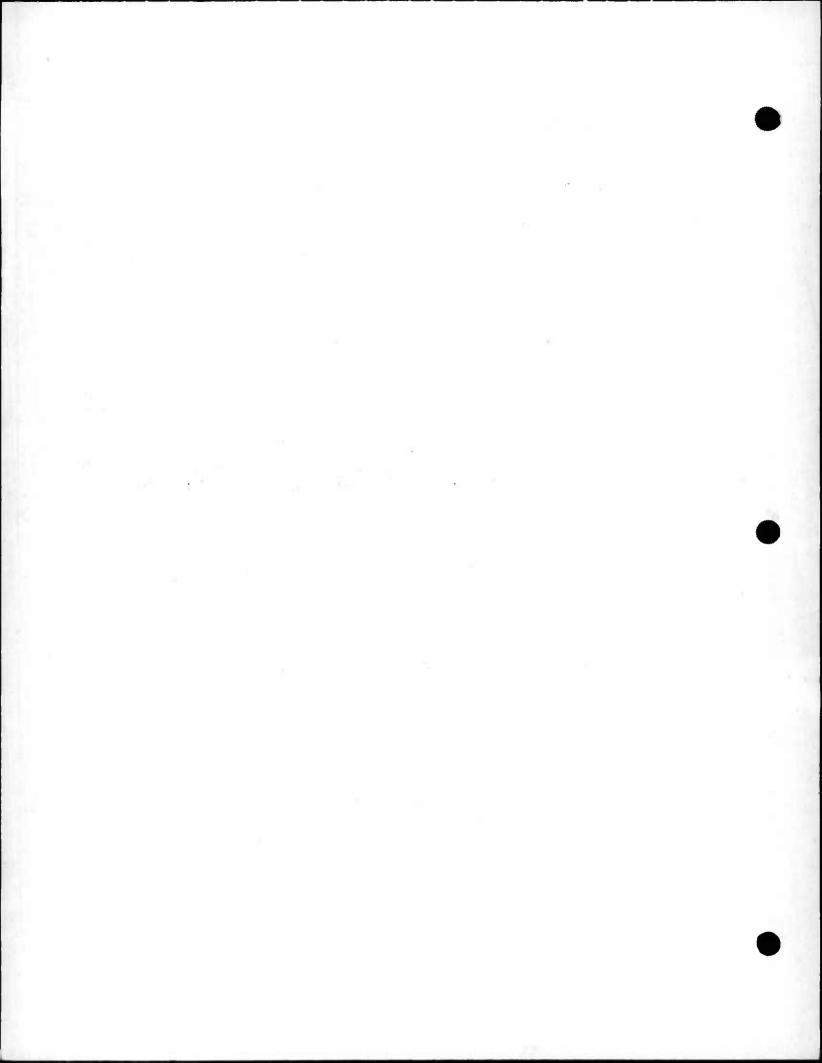
7220 PARK 31. DATE FILED (Month, Day, Year)

JUL 1 9 1995

LAKHANI) 2120

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First, Mic	della Lanti				IOAI	LOI	DLA			G. NO.		_		
		DORIS LORRAIN		DITITO							2. DATE OF D	DAY		EAR	ME OF DEATH	
		4. SOCIAL SECURITY NUMBER	ALL TAN	5. SEX	6. AGE (In yrs.	ant hirthday)	IF UNDE	D 4 VEAD	IF UNDER	204 1400	7. DATE OF BI				- 70 F.M	
		220-18-2530		1 M 2 X F	71		MONTHS	DAYS	HOURS	MIN.	(Month, Day	102	1 6.	Country)		
pinou		9a. FACILITY NAME (If not institut	tion, give s	treet and number)			9b. CIT	Y. TOWN (OR LOCATI	ION OF DE	L	1,72				
e.	8	Washington Co	ountv	Hospita	1				ersto							
3.1, 2	5	RESIDENCE OF DECED	DENT										101101	LING	JOR	
Page	DIRECTOR	20001035	b. COUNTY			10c. C/1	Y, TOWN								LIMITS?	
Ĕ		Maryland 100. STREET AND NUMBER	wasn	ington			нас	erst	LOWN							
st. De	RA	1741 Edgewood	1 111 1	le Ciral	0			101	217	_		- 1			COUNTRY?	
020 physician. burial-transit permit. Pages 1, 2, 3 should	FUNERAL	11. MARITAL STATUS	11111	12. WAS DECEDEN		RMED	13	WAS DEC			UC ODICINO (C.	alfu Va a				
020 physi buria		1 Never Married 2 Mar		FORCES? 1	YES 2 X	NO		If yes, sp	ecify Cuba	ın, Maxicai	n, Puarto Rican,	atc.)	C.W.C.	Black, Whi	Ita, atc.	
oding the	ВУ	3 Widowed 4 Divorced	1		WIT ON DAILS			I [] TES	2 NO	Specify	·.			Specify: Wi	nite	
21215-0020 al or attending physic for use as the burial	COMPLETED	15. DECEDE (Specify only high	NT'S EDUC	CATION completed)	16a. I	ECEDENT'S	USUAL O	CCUPATIO	ON ost of working	na	16b. KIND	OF BUSI				
21 tal or		Elementary/Secondary (0-12)		College (1-4 or 5	*/	Give kind of fe. Do NOT u										
AND the hosp detached	Ř	TO EATHERN MANE CO. AND A		Year	Se	lf-En	ίρτολ	red						ing		
YLA by the be der		17. FATHER'S NAME (First, Middle	, Last)									Maiden Se	urname)			
	BE	Scott Barber 19a. INFORMANT'S NAME (Type/)	Print)		Τ.	Ob. MAII IM	400050	0 /0			otter					
	6	Melody Hain	1111.0												782	
		20s. METHOD OF DISPOSITION				E AND DATE				lewal			Injury occured 10d. INSIDE CITY LIMITS? 1			
ORE 6 may ector, pa		1 Buriel 2 X Cremation :		oval from Stata	cemetery, c	remetory or o	ther place)			7/21		SITH SENTHPLACE (State or For Country) SITH SENTHPLACE (State or For Country) Maryland 9c. COUNTY OF DEATH WASHING TON 10d. INSIDE CITY LIMITS? 1			51F	
Page al din		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY														
BALTIMORE, er death. Page 6 may be the funeral director, page and.	1	Douglas A. Fiery Funeral Home 21742-3489														
B. B. the removal.		23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate														
NW 3 - 2		IMMEDIATE CAUSE (Finel Onset and Death														
1 File 2		IMMEDIATE CAUSE (Finel Onset and Death														
ted within 24 completely fille ial, cremation, event, the		resulting in death) a. AROLOPUMONARY HAUST DUE TO (OR AS A CONSEQUENCE OF):												25 MINUTES		
P 2 2 2	z												2/ 16/100			
8 " O F	CERTIFICATION	Sequentially list conditions, If any, leading to immediate b. CONGESTIVE HEART FAILURE 36 HOU										16 MOURS				
BOX ficate be e physician ne prior to	S	cause. Enter UNDERLYING CAUSE (Disease or Injury	₹ .	CORDN	OR AS A CONS	ARTE	RY	λ	LIFE	ASE					1FMRS	
D.O. B n certificat nding phy Hygiene p	1	that initiated eventa resulting in deeth) LAST		DUE TO	(OR AS 'A CONS	EOUENCE O	r): `									
ath ath	H	resulting in death, Exer		1												
이 원 등 를	- 10	PART II. Other significent of	ondition	contributing to	deeth but not	resulting	in the ur	nderlying	g cause (given in i						
OR that I and the any I	MEDICAL	MORBID OF	SEST	TY. HY	PORTEN	Sion	1 6	LYPT	sell	PINE	1.0		_	Approximate Interval Between Onset and Death 25 MINUTES 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
Sign Sign Heal	Ä			,			1	7	/			120 2			-20	
C e e e	z I	DID TOBACCO USE	CONTR	RIBUTE TO CA	USE OF DE	ATH YE	S 🔲 I	NO. Z	UNC	ERTAIN						
ITAL N: The lav scate has State Dep	SICIAN:	25. WAS CASE REFERRED TO ME EXAMINER?				CE OF DEA	TH (Check	only one)						a. BIRTHPLACE (State or Foreign Country) Maryland COUNTY OF DEATH ASHING TOW 10d. INSIDE CITY LIMITS? 1 YES 2 WNO CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Bieck, White, atc. Specify: White White White CINDUSTRY Lothing 10d. INSIDE CITY LIMITS? 1 YES 2 WNO CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Bieck, White, atc. Specify: White CINDUSTRY Lothing 10d. INSIDE CITY LIMITS? 1 YES 2 WNO CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Bieck, White, atc. Specify: White CINDUSTRY Lothing 10d. INSIDE CITY LIMITS? 1 YES 2 WNO CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Bieck, White, atc. Specify: White Indian Specify: Who will be a country of the country of t		
F VIT SICIAN: The certificate the State , or Item	YS!	1 YES 2 NO		HOSPITAL:	ER/Outpatient	3 DOA	4 Nur		e 5 🗆 Re	sidence	8 Other (Spec	clfy)		S. BIRTHPLACE (State or Foreign Country) Maryland COUNTY OF DEATH ASHINGTON 10d. INSIDE CITY LIMITS? 1		
OF VITA PHYSICIAN: The this certificate hi with the State or rked, or Item	PHY	27. MANNER OF DEATH		28a. DATE OF (Month, De		28b. TIM	E OF URY	28c. INJ	URY AT		28d. DESCRIBE	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
ON OI DING PHYS After this death with	à	Natural 5 Pend Prives	iing stigation				M	1 🗆 1	YES 2	NO						
O 5 < 5		3 Suicide 8 Coul-	id not be	28e. PLACE Of building,	F INJURY — AI I atc. (Specify)	ome, farm, :	street, fact	tory, office	•		281. LOCATION City or Tow	(Street and n, State)	d Number or R	lural Floute N	lumber,	
DIVISION ATTENTON OINECTOR: hours after Item 28 Is	19 J	non CERTIFIER														
TAL O	를															
	COMPLI	2 MEDICAL	EXAMINER	R: On the basis of a	ramination and/o	Investigation	n, in my o	pinion, d	eath occur	ed at the t	time, data and p	lace, and	due to the ce	SENTHPLACE (State or Foreign Country) Maryland COUNTY OF DEATH JASHING TON 10d. INSIDE CITY LIMITS? 1		
THE HOSPI THE FUNE filed within PORTANT:	H	296 SIGNATURE AND TITLE OF	CERTIFIER	11 5					29c. LICE	NSE NUM	BER	12	29d. DATE SI	Maryland c. COUNTY OF DEATH UASHINGTON 10d. INSIDE CITY YES 2 NO		
5 5 3 X	2	Hand long					.73	589	2		76	20/90	5			
	-	30. NAME AND ADDRESS OF PER	PA -	COMPLETED CAUS	SE OF DEATH (IT	EM 27) (Type,				1	11.			1	()	
		31. DATE EILED MORTH Day Vand	NY	A 30 PECETPA	P'S CHATUE	1799	H	DWE	W 1	<u> </u>	74/76	FRS	10W1	1/4	0 2/740	
		JUL 2 1 1995	Jul	in diwalin	R'S GNATURE											



Pages 1, 2, 3 permit. funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 BALTIMO...., nours after death. Page 6 may be 8 and completely filled in by the burial, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 68760. attending physician a requires that the death certificate be n signed by the attend if Health and Mental H has been : Dept. of H the State OR ATTENDING PHYSICIAN: with t DIRECTOR: After the hours after death was

HOSPITAL

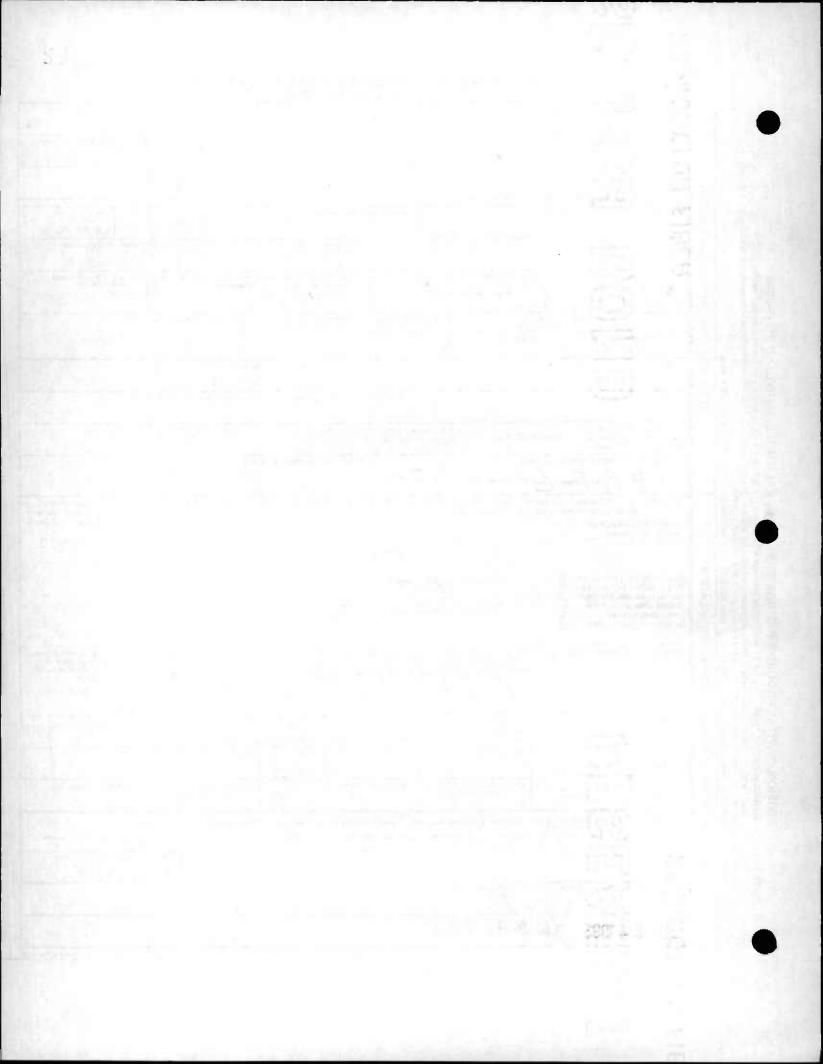
should

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1, DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH Bethany Carol Martin JUTY 1995 21 5:40 P 4. SOCIAL SECURITY NUMBER 5 SEY 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 11/15/1994 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 6 MONTHS 8 None 1 M 2 M F YRS. Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 13811 Weaver Ave. DIRECTOR Maugansville Washington RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10h COUNTY 10d. INSIDE CITY MD. Washington Maugansville 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13811 Weaver Ave. U.S.A. 21767 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 M NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Nover Married 2 Married BY specify: White 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) None None 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Michael . Melanie S. Martin notified at R. Martin BE Michael R. Martin 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13811 Weaver Ave. P.O Box 398 Maugansville, Md. 21767 2 pe 20a, METHOD OF DISPOSITION

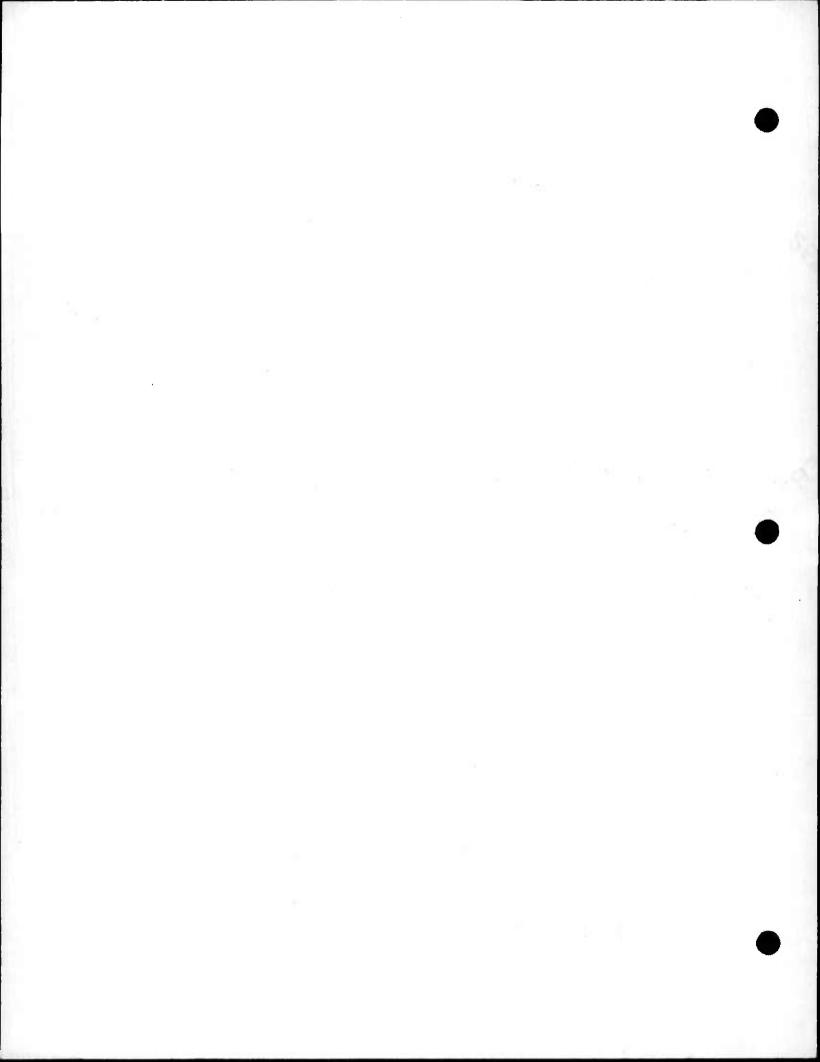
1 K Burlel 2 Cremation 3 Re
4 Donation 6 Other (Specify) 20b. PLACE AND DATE of DISPOSITION (Name of Competery, cremetory, or other place) Reiff's Mennonite Church Cemetery 7/23/95 20c. LOCATION - City or Town, State must Cearfoss, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY H.M Zimmerman And Son Funeral Home larlen Greencastle, Pa. 17225 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximata shock, or heart feilure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Finel Onset and Death the disease or condition greenwar weeks resulting in deeth) traumatic event, DUE TO YOR AS A CONSEQUENCE OF CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events other 1 DUE TO (OR AS A CONSEQUENCE OF) reaulting in death) LAST 6 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24a. WAS AN AUTOPSY PERFORMED? Word any 1 TES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Hem HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 - YES 2 NO 4 ☐ Nursing Home 5 🕅 Rasidenca 6 ☐ Other (Specify) 0 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 26c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 26t. LOCATION (Street and Number or Rural Route Number, City or Town. State) 69 3 Sulcide COMPLETED 6 Could not be 4 Homicide 28 29s. CERTIFIER Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. FUNERAL I within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1 2 MEDICAL EXAMINER: On ition and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFUL 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 22/95 11266 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 580 JUL 2 4 1995 REGISTRAR SIGNATUR



 \mathbf{P}_{M}

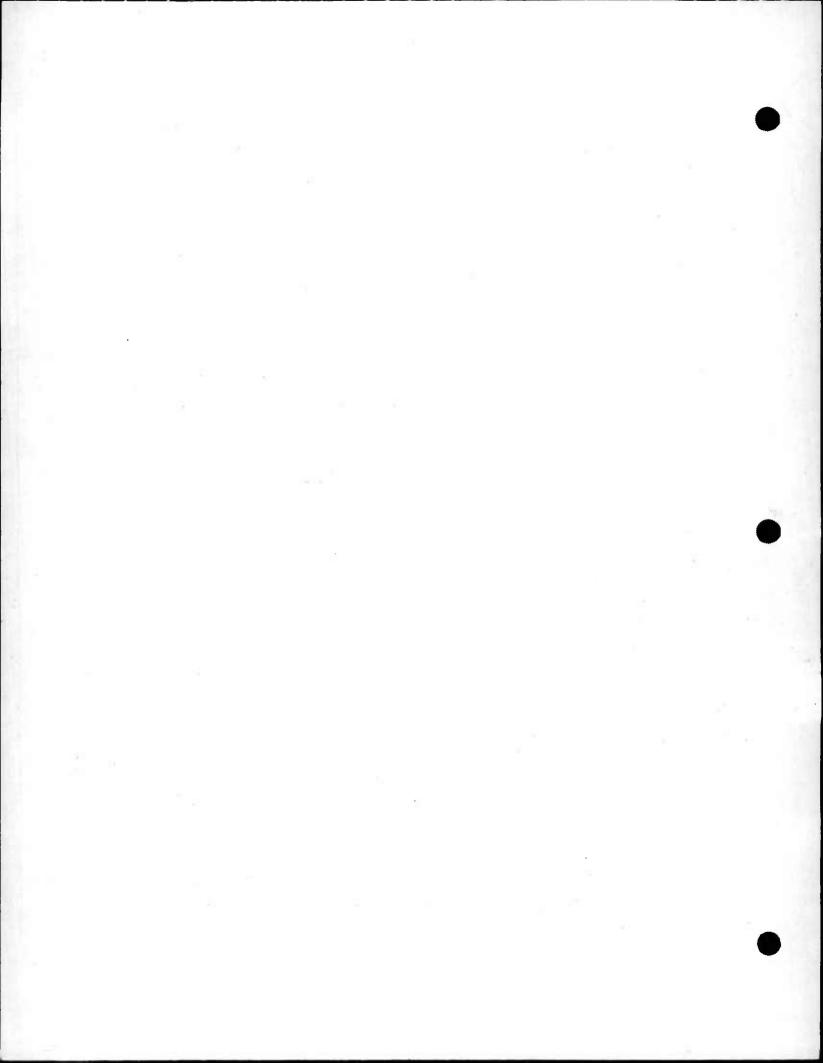
		1. DECEDENT'S NAME (First, Middle, La MARVIN	ent)	МТ	LLER		2. DATE OF I	24 19	95	3. TIME OF DEATH 11:25 PM					
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday	F UNDER : YEAR	IF UNDER 24 HRS.	7. DATE OF E	HRTH	A. BURTHP	M ACE (State or Foreign					
29	ļ	220-15-1755 Sa. FACILITY NAME (If not institution, gi	1 🔀 M 2 🗆 F	12 YRS.	MONTHS DAYS			71983		Maryland					
. 3 sho	OR	frederick mem		spital	frede	or location of the cick	DEATH		EDERI						
1, 2	5	RESIDENCE OF DECEDENT 10e. STATE 10b. COU													
permit. Pages 1, 2, 3 should	DIRECTOR	CARLO COLO.	ashington		rr, rown on Loc Smithsbu				- 1	10d. INSIDE CITY LIMITS? 1 YES 2 NO					
	FUNERAL	100. STREET AND NUMBER 10944 White Ha	all Road		1	01. ZIP CODE 21783		10g. Cr							
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit notified at once.	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Olvorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	EVER IN U.S. ARMED YES 2 X NO AR OR DATES	If yes, s	CENDENT OF HISPA specify Cuban, Maxic S 2 NO Spec	can, Puerto Ricar	pecify Yes or No—	14. RACE Black,	- American Indien, White, etc.					
215-0 attending ise as the		15. DECEDENT'S E	DUCATION	18e. OECEDENT	S USUAL OCCUPAT	TION	16b, KIN	D OF BUSINESS/IN	DUSTRY	WILLEC					
D 212 pital or a ed for us	COMPLETED	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4 or 5+	life. Do NOT	f work done during n use retired.) .rm Work.	nost of working		gricultu							
YLAND 2 by the hospital be detached to at once.		17. FATHER'S NAME (First, Middle, Last)	James H.	Miller				, Maiden Surname)							
MARY retained b 5 should t notified a) BE	19a. INFORMANT'S NAME (Type/Print)			IG ADDRESS (Street	and Number or Rura			p Code)						
E, M y be ret page 5 s	٩	James H. Mil	ler				d. Smit								
HOR e 6 ma rector, p		20a. METHOD OF DISPOSITION 1	amoval from Stata	cemetery, crematory or Mennonite	eof disposition () other piece) Rei Church Ce	ff's emetery 7	/28/95								
death. Pag death. Pag e funeral dii ii.		21. SIGNATURE OF FUNERAL SERVICE	LICENSEE		22. NAME	AND ADDRESS OF F	ACILITY	1,000		•					
- 0 - 0		Zimmerman And Son Funeral Home Greencastle, Pa. 17225 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate													
d in to		immediate cause (Final disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reepiratory arrest, ehock, or heart fellure. List only one ceuse on eech line. immediate CAUSE (Final disease or condition resulting in death) a. Our TO (OR AS A CONSEQUENCE OF):													
O. BOX 68760 artificate be executed within 24 in physician and completely fille giene prior to burial, cremation, other traumatic event, the	ATION	Sequentielly list conditions, if any, leading to immediate ceuse. Enter UNDERLYING b													
P at Hy	CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	c	OR AS A CONSEQUENCE	OF):										
DS, F the death the attend Mental		PART II. Other algnificent condit	ions contributing to	leeth but not rasulting	in the underlying	na ceuse aiven in	Part i. 24a	WAS AN AUTOPSY	LIMITS? 1 YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. or No— 14. RACE — American Indien, Black, White, etc. Specify: White NESS/INDUSTRY Liture Urname) State, Zip Code) rg, Md. 21783 ATION — City or Town, State Cfoss, Md. 1 Home atory arreet, Approximate Interval Batween Onset and Death Donet and Death LITOPSY AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO DURY OCCUREO AND WARE A Number or Bural Route Number, Thanks Skale Park						
COR ires that signed by leafth an	MEDICAL							PERFORMED?	0	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
		DID TOBACCO USE CON	NTRIBUTE TO CAL	JSE OF DEATH Y	ES NO 1	UNCERTAI	IN 🗆		1	YES 2 NO					
TA The The I the De ate De	S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF OE	ATH (Check only one)									
F VITAL F SICIAN: The law r s certificate has be th the State Dept.	PHYSICIAN	1 XVES 2 NO		ER/Outpetient 3 N DOA	OTHER: 4 - Nursing Ho	me 5 🗆 Raeldence	8 Other (Spe	icity)							
이 돈 풀볼 뭐		27. MANNER OF OEATH 1 Netural 5 Pending	28a. OATE OF I	NJURY Face 286. TI	IJURY W	JURY AT ORK? YES 2 PAO	28d. OEŞCRIB	E HOW INJURY OC	CUREO	1 /22					
N A S S	ED BY	2 Accident 3 Suicide 8 Could not be determined determined determined determined determined determined determined.													
DIVISION ATTERNATE DIRECTOR Hours after 18	ET	a 4 nonicos determined													
HOSPITAL FUNERAL within 72 h	COMPLET									and manner se stated.					
TO THE HOSPITAL TO THE FUNERAL De filed within 72 h IMPORTANT: If i	BE	29c. LICENSE NUMBER 29c. LICENSE NUMBER O.C.M.E. 29d. DATE SIGNED (I													
228	유	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE			eet, Ba									
		31. DATE FILED (Month, Day, Year)	2. REDISTRAF	TII PE	mi stre	bet, bd.	T CTHOT	e, Har	, ranc	. 21201					
		JUL 2 6 1995 A	The property	and draft											

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO

		REGISTRAR			CI	EKIIF	ICALE	JE DEATH		REG. NO					
		1. DECEDENT'S NAME (First	, Middle, Last)						2. D	ATE OF DEATH		3	TIME OF DEATN		
				Lowe11	Mil:	ler			_	Tuly	- 40	YEAR	0147 M		
		4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER 1 YE	AR IF UNDER 24 H	s. 7. D	ATE OF BIRTH		A. BIRTNPL	ACE (State or Foreign		
		220-15-246	57	1 ⊠ M 2 □ F	15	YRS.	MONTHS DA	YS HOURS ME	v. 2	1718/198	0	Country)	Maryland		
3 should		9a. FACILITY NAME (If not in	nstitution, give s	street and number)			Oh CITY TO	WN OR LOCATION O				TY OF DEA			
3 sh	œ .	Washington			1		T	erstown	PUEAIN						
2,	16	RESIDENCE OF DEC	-	y nospica			nage	ISCOWII			wa	shing 	LOII		
les 1.		10a. STATE	10b. COUNT	Υ		10c. CIT	Y, TOWN OR L	CATION				10	Od. INSIDE CITY		
Pages	DIRECTOR	MD.	Was	shington		5	Smithsh	urg					LIMITS?		
permit.		10e. STREET AND NUMBER						101. ZIP CODE			40 01717		YES 2 NO		
	2	10944	White	Hall Rd.				21783			-	U.S.A	AT COUNTRY?		
020 physician. bunal-transit	FUNERAL	11. MARITAL STATUS													
20 mysic unial	[교]	1 Never Married 2	Married	FORCES? 1	T EVER IN U.S. AR	MED IO	13. WAS	DECENDENT OF HIS	SPANIC OR xican, Pua	IGIN? (Specify Year rio Rican, etc.)	or No-	14. RACE — Black, V	- American Indian, White, atc.		
215-0020 attending physician, se as the buñal-tran	l Ma	3 Widowed 4 Divo		IF YES, GIVE W	WAR OR DATES		1 🗆	YES 2 NO S	ecify:			Specify:	White		
21215-0020 al or attending physic for use as the bunal	ED	15 DEC	EDENT'S EDU	CATION	10- 00	OCOCUTIO									
or at	E	(Specify only	y highest grade	completed)	(Gi	ive kind of a	WORK done during	most of working		16b. KIND OF BUS	SINESS/INDU	STRY			
d for	اۃا	Elementary/Secondary (0 C)	⊢12)	College (1-4 or 5 +	+)	_	m Work			Agr	icu1tu	are			
AND the hospital detached for once.	COMPL					rai	III WOLF								
LAN the ho detach	8	17. FATNER'S NAME (First, M		ames H. M	fillor					st, Middle, Malden	Sumame)				
MARYLAND retained by the hospits 5 should be detached notified at once.	出			ames II. Fi						K. Eby					
MAR retained 5 should notified	٥	19a. INFORMANT'S NAME (7		M411	198	. MAILING	ADDRESS (Str	eet and Number or R	iral Floute N	lumber, City or Tow	n, State, Zip (Code)			
	-	Ja	mes H.	Miller		1094	4 Whit	e Hall F	d. S	mithsbu:	rg, Mo	1. 21	783		
R Pay		20e, METHOD OF DISPOSITE	ION	our from State	20b. PLACE	ND DATE	of Disposițioi	(Nameol		ATE 20c. LO	CATION — C	Ity or Town	, State		
ALTIMORE, death. Page 6 may be funeral director, page		4 Donation 5 Other	(Specify)	Over from State	Mennon	matory or o ite (ther placa). KE hurch	Cemetery	7/28	/95 Cea	rfoss	. Md	1500		
ALTIN death. Pag tuneral dir f. examiner		21. SIGNATURE OF FUNERA	L SERVICE LI				22. NAM	E AND ADDRESS OF	FACILITY						
ALTI death. Pa funeral xamine		→ H. M.	N.T.	Lumn	eina	3-	Zi	mmerman				lome			
S after des n by the fur removal.		11.11.	~~~				GI	eencast1							
		23. PART i. Enter the di ahock, or he	iseases, or c asrt failura.	complications that List only one cau	t csused the deuse on asch line	ath. Do r	not antar tha	moda of dying,	such ss o	ardiac or respi	ratory arre	at,	Approximate Interval Between		
filled on or			IMMEDIATE CAUSE (Final Const and Death												
≥ 		disease or condition	resulting in death)												
d within complete		DUE TO (OR AS A CONSEQUENCE OF):													
	2	Samuelally, that are distance of the													
OX 68 e be execut sician and c nior to bun traumatic	CERTIFICATION	Sequentially list conditions, If any, leading to immediata DUE TO (OR AS A CONSEQUENCE OF):											 		
ate be or systerian prior to	Į.	cause. Entar UNDERLYING													
entificat ing phy giene p	프	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											 		
ending P. Cert	F	resulting in death) LAS	r												
DS, F ne death the atter Mental	B			σ									 		
L RECORDS, P.O. Bo law requires that the death certificate is been signed by the attending physi ept. of Health and Mernal Hyglene pr 23 shows any Injury, or other th	4	PART ii. Othar significa	nt condition	s contributing to	death but not re	aulting i	n tha undari	ying cause given	in Part i	. 24a. WAS AN			ERE AUTOPSY FINDINGS		
res that the igned by th ealth and N	EDICAL									PERFOR			MILABLE PRIOR TO IMPLETION OF CAUSE		
signed Health &										1 TYES 2	SK NO		DEATH?		
w requ	Σ	DID TOBACCO U	SE CONITI	DIRI ITE TO CAI	LISE OF DEAT	ru ve	S D NO	LINICEDT	AINI 🖂	1 '		1 1	YES 2 NO		
4 5 50 -	A N	25. WAS CASE REFERRED TO		NIBOTE TO CA			N (Check only o		AIN L						
그 두 일 등 등	PHYSICIAN:	EXAMINER?	, medicale	HOSPITAL:			OTHER:								
PHYSICIAN: The this certificate with the State	₹ I	27. MANNER OF DEATH		15 Inpetiant 2			1	lome 5 - Rasiden	-						
NG PHYS fer this cath with marked,	4		Pending	28s. DATE OF (Month, De	ay, Year)		URY	INJURY AT WORK?		DESCRIBE HOW IF		TYO4	oned		
After the death	À		Investigation		2495	730	1	YES 2 NO	NO.	your my	all a	710	,,,,,,,		
) 5 4 5 m			Could not be	28a. PLACE OF building,	F INJURY — At hor atc. (Specify)	ne, farm, s	thet, factory, o	ffica	28f. L	OCATION (Street a	nd Number o	r Rural Rout	a Number,		
DR ATTEN DR ATTEN DIRECTOR: hours after item 28 is		4 Nomicide	detarmined	CUL	MINGL	1 f m	71	1/5 LAKS	and the	FRG I	PERI	ck	CG.		
DIRECT POURS	MPLE	29a. CERTIFIER (Check only 1 CERT	IFYINO PNYSI	CIAN: To the best of	my knowledge, des	th occurre	d at the time.		-	cause(s) and man	ner se eteled				
PITAL PTAL T: #	₹			R: On the basis of ax									od manner se stated		
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	8	295. SIGNATURE AND TOLE								and place, and	don to the	CE000(E) EI	d mainler as stated.		
물 물질 등	H	280. SIGNATURE AND TOTAL	7111	0				29c. LICENSE	NUMBER		29d. DATE	SIGNED (Mo	onth, Day, Year)		
TO THE HOSPIT TO THE FUNERA De filed within 7	<u>و</u>	- 1	MA	ulu				DI	264	0	J.	142	5 1995		
		30. NAME AND ADDRESS OF	PERSON WHO	O COMPLETED CAUS	SE OF DEATN (ITEM	27) (Type,	Print)		,		U	1			
		HN	Wee.	ks 4	180 N	01/1	7erx	Av H	AB	VS Town	, ks	D			
1		31. DATE FILED (Month, Day,		32. REGISTRA	R'S SIGNATURE				1			2.72			
		JUL 2 6 199.	5 Jul	in Okuelson	Radi								r		



2200

1 - YES 2 NO

- American Indien, White, etc.

Specify Black

Princess Anne N

21853

Approximate Interval Between

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

Onset and Death

8. BIRTHPLACE (State or Foreign

9c. COUNTY OF DEATH

HNNE

10g. CITIZEN OF

WICOMICO

2. DATE OF DEATH MONTH

46 7. DATE OF BIRTH (Month, Day, Year, IF UNDER 24 HI 9-05-3488 1 M 2 X F funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR PENINSULA REGIONAL MEDICAL CENTER SALISBURY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 27 OX 104. STREET AND NUMBER FUNERAL 10f. ZIP CODE 30% 21853 12. WAS DECEDENT EVER IN U.S. ABMED hours after death. Page 6 may be retained by the hospital or attending physician, 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. It yee, specify Cuban, Maxican, Puerto Rican, stc.)

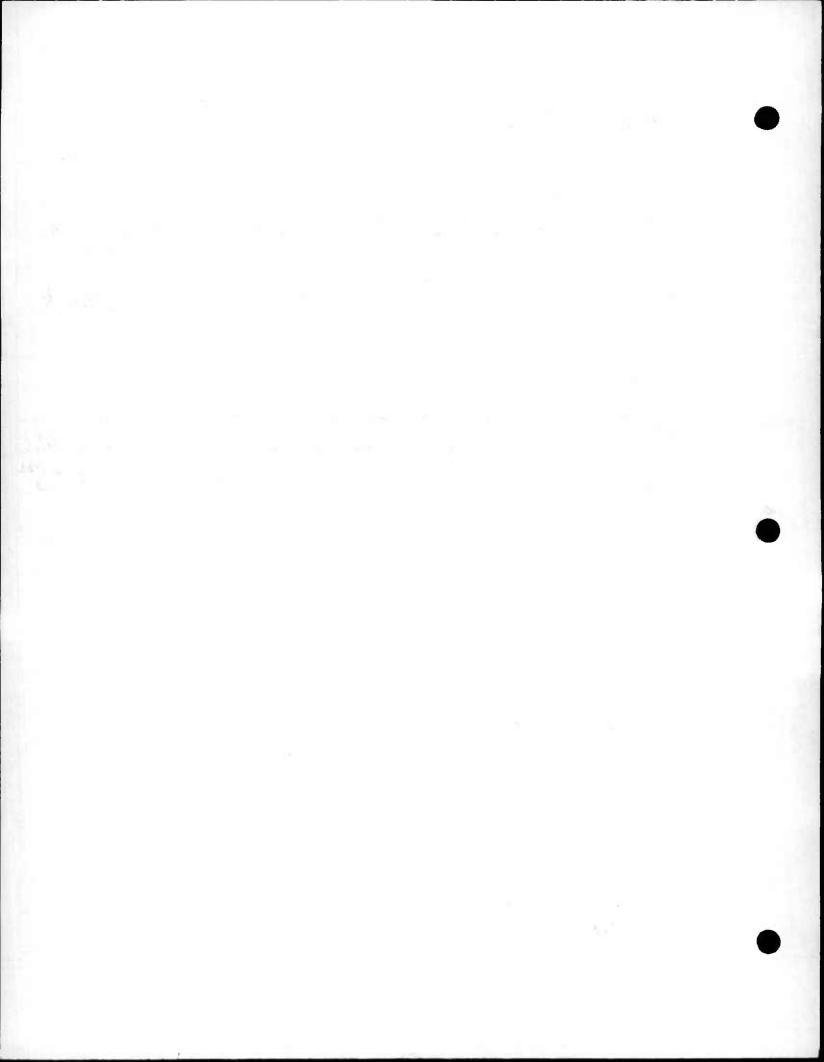
1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married: 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5 +) Aborer notified at BE (2 Pe METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITIO must Burlet 2 Cremation 3 Rem examiner 21 SIGNATURE OF FUNE 30639 Hampden HUE. the attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or removal. medical 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Fine) other traumatic event, the disease or condition 0 reculting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 MEDICAL CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Diseese or injury that initieted events resulting in deeth) LAST 6 23 shows any injury, PART II. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? certificate has been signed by h the State Dept, of Health and 1 YES 2 FINO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: **EXAMINER?** OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 ng Home 5 - Residence 8 - Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY with t 28b. TIME OF INJURY 28c. INJURY AT marked, 28d. DESCRIBE HOW INJURY OCCURED 1 P Netural 1 YES 2 NO DIRECTOR: After the hours after death death v BY 2 Accident 28 ls n 3 Sulcide 28a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my known TO THE HOSPITAL OF THE FUNERAL DE FILED within 72 ho 2 MEDICAL EXAMINER: On and due to the cause(a) and mennar as stated. 296, SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER BE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1104 32. REGISTRAR'S SIGNATURE

1. DECEDENT'S NAME (First, Middle, Last)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

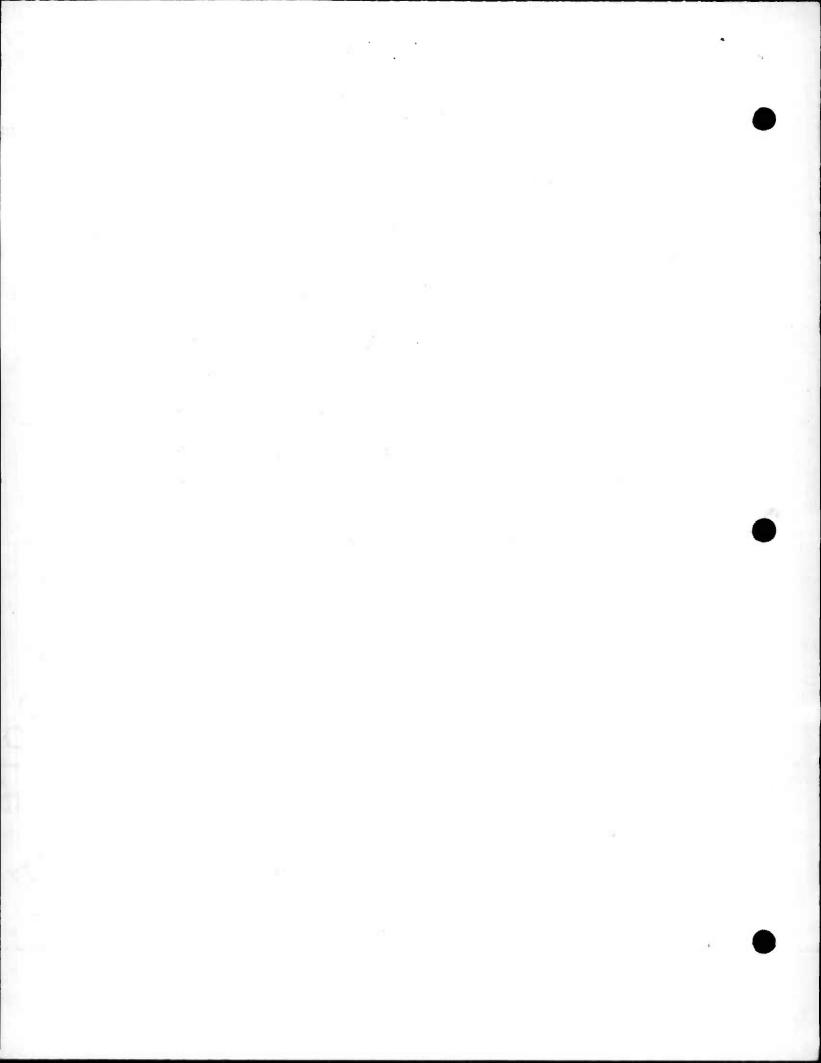


FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -"REGISTHAN

1. DECEDENT'S NAME (First, Middle, Last)

MARY CERTIFICATE OF DEATH 2. DATE OF DEATN 3. TIME OF DEATH JULY 11, 1995 **KELLEY** OCHLECH 2330 4. SOCIAL SECURITY NUMBER 023-16-2856 6. AGE (In yrs. last birthday)
71 YRS. 5. SEX 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS MASS. 1 🗆 M 2 💢 F YRS. Pages 1, 2, 3 should 99. FACILITY NAME (If not institution, give street and number) 305 CAROLINE STREET 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR WORCESTER RESIDENCE OF DECEDENT WORCESTER 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY OCEAN CITY 1 YES 2 NO permit. 305 CAROLINE STREET FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 101. ZIP CODE 21842 funeral director, page 5 should be detached for use as the burial-transit retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, sic. 1 Never Married 2 Married If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 ONO Specify: BY 3 Widowed 4 Divorced Specify: WHITE 15. DECEDENT'S EDUCATION COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ntary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) THOMAS F. KELLEY MARY F. BRADLEY notified at BE 190. INFORMANT'S NAME (Type/Print)
CHARLES W. OCHLECH 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 305 CAROLOINE ST. OCEAN CITY, MD., 21842 burs after death. Page 6 may be must be 20s. METNOD OF DISPOSITION
1 Burlel 2 Cremalion 3 Ramoval from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State SALISBURY CREMATORY SAL ISBURY 21. SIGNATURE OF FUNERAL SERVICE LICENSE examiner 22. NAME AND ADDRESS OF FACILITY ULLRICH FUNERAL HOME BERLIN, MD. nding physician and completely filled in by the Hygiene prior to burial, cremation, or removal. medical 23. PARTA. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, **Approximete** ehock, or heert failure. List only one ceuse on eech line. interval Between **IMMEDIATE CAUSE (Fine) Onset and Death** the diseese or condition DUE TO (OR AS A CONSEQUENCE OF) recuiting in death) INFARCTION other traumatic event, HOURS DIVISION OF VITAL RECORDS, P.O. BOX 68760, CERTIFICATION Sequentieily liet conditiona, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evente reauiting in deeth) LAST 6 signed by the atter Health and Mental PART ii. Other aignificent conditions contributing to deeth but not recuiting in the underlying cause given in Pert i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE this certificate has been signed by with the State Dept. of Health and riked, or Item 23 shows any I 1 - YES 2 XNO OF DEATH? 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER:
4 | Nursing Nome 5 | Residence 8 | Other (Specify) OR ATTENDING PHYSICIAN: 1 YES 2 NO ☐ Inpatient 2 ☐ ER/Oulpatient 3 ☐ DOA 27. MANNER OF DEATN DIRECTOR: After this cer hours after death with th item 28 is marked, o 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 8 Could not be determined 4 Nomicide TO THE FUNERAL DIRECT
be filed within 72 hours a
IMPORTANT: If item 2 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. HOSPITAL 2 🐹 MEDICAL EXAMINER: On the besis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner as stated 29b. SIGNATULE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 뿚 106241 7-12-95 2 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) DOROT HY DLZWORTH 32. REGISTRAR'S SIGNATURE 1995 whi Dendem Randell



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a form of the form of the form of the completely filled in by the formal director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR			IMENT OF HEALTH AND N	MENTAL HYGIENE REG. NO.	E	
1	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	YEAR YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	BERNARD JOSEPH 5. SEX 6. AGE (In yrs. last		JR . IF UNDER 1 YEAR IF UNDER 24 HRS.	JUNE 24,	1995	10:30 A. M HPLACE (State or Foreign
	200 000 000 000 000 000 000	1 Ø M 2 □ F 73	YRS.	MONTHS DAYS HOURS MIN.	(Month, Day, Year)	Coun	ITSBURG, MD.
~	9e. FACILITY NAME (If not institution, give street	et and number)		9b. CITY, TOWN OR LOCATION OF DE		9c. COUNTY OF	
Ď.	38 FEBERAL AVE.			EMMITSBURG		FREDER	ICK
DIRECTOR	10a. STATE 10b. COUNTY	EDICK		, TOWN OR LOCATION			10d. INSIDE CITY LIMITS?
	MARYLAND FREDS	ERICK	Elv	MITSBURG			1 X YES 2 NO
ERA	38 FEDERAL AVE.			21727		U. S.	WHAT COUNTRY?
FUNERAL		12. WAS DECEDENT EVER IN U.S. ARN FORCES? 1 X YES 2 NO		13. WAS DECENDENT OF HISPANI If yes, specify Cuben, Maxican	C ORIGIN? (Specify Yes	or No.— 14. RAC	E — American Indian, ck, White, etc.
B	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES WW TT		1 TYES 2 NO Specify:		Spe	
9	15. DECEDENT'S EDUCA' (Specify only highest grade co	TION 16a, DEC	EDENT'S U	JSUAL OCCUPATION ork done during most of working	16b. KIND OF BUS	INESS/INOUSTRY	
PLE	Elementary/Secondary (0-12)	Conege (1-4 or 5+)		ork done during most of working or retired.) CONTRACTOR			SBAUM & OTT
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	[PAII	VITNE		IE (First, Middle, Maiden S	AINTING Surname)	
BE (D JOSEPH OTT, SE			ELDER		
5	198. INFORMANT'S NAME (Type/Print) EVELYN L. OTT	196.	MAILING.	ADDRESS (Street and Number or Rural ADERAL AVE., EMMIT	Oute Number, City or Town	21727	
	20a. METHOD OF DISPOSITION 1 St Burlel 2 Cremetton 3 Remove	20b. PLACE A	ND DATE O	F DISPOSITION (Name of		CATION — City or T	own, State
	4 Donation 5 Other (Specify)	NEW ST	atory or oth	SEPH'S 6/28. 9		ITSBURG,	MD. 21727
	21. SIGNATURE OF FUNERAL SERVICE LICEN	Skiles		22. NAME AND ADDRESS OF FAC	SKILES	FUNERAL	
	23. PART i. Entar tha diseases, or con	molications that accord the de-	th Dan	210 W. MAIN ST	., EMMITSE	BURG, MD	
	ahock, or haart fallura. Lis iMMEDIATE CAUSE (Final	st only one cause on each line.			as cardiac or respir	ratory arrest,	Approximata interval Between Onset and Death
1	disease or condition reaulting in death)	Colon					3 years.
_		DUE TO (OR AS A CONSECU	UENCE OF):			
TIO	Sequantially list conditions, if sny, leading to immediate	DUE TO (OR AS A CONSEOR	UENCE OF	:			
FICA	cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events	OUE TO (OR AS A CONSEQU	UENCE OF	•			
CERTIFICATION	reaulting in death) LAST			,			į
	PART ii. Other significant conditions	contributing to death but not re	auiting in	the undarlying cause given in F	Part I. 24s. WAS AN A	AUTOPSY 24	b. WERE AUTOPSY FINDINGS
EDICAL					PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Σ	DID TOPACCO HEE CO	ONITRIBUTE TO CALL				^ -	1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CO	ONIRIBUTE TO CAUS	SE OF	DEATH YES NO	<u> </u>		
SIC		HOSPITAL:		OTHER:			
	27. MANNER OF DEATH 1 X Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	IRY WORK?	28d. DEŞCRIBE HOW IN	JURY OCCUREO	
В	2 Accident Investigation	26e, PLACE OF INJURY — At hom	na, farm, at	M 1 YES 2 NO	281. LOCATION (Street at	nd Number or Rural	Pouts Number
TED	4 Homicide determined	building, etc. (Specify)			City or Town, State)		
COMPLET				d at the time, data and place, and dua t			
SO	2 MEDICAL EXAMINER:	On the basia of axamination and/or in	rvestigation	, in my opinion, death occured at the t	ime, data and place, and	dua to the cause(a) and manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	Shall		29c. LICENSE NUM D36			(Month, Day, Year)
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF OEATH (ITEM	27) (Type	Prin D 4 0 L	(a) 10)	OUNE Z	6, 1995
	31. DATE FILED (Month, Day, Year)	(ah M1). 103	0-6	entietica i	uarys	m (PA 17325
	JUL 1 7 1995	32. REGISTRAR'S SIGNATURE	arlett			1	

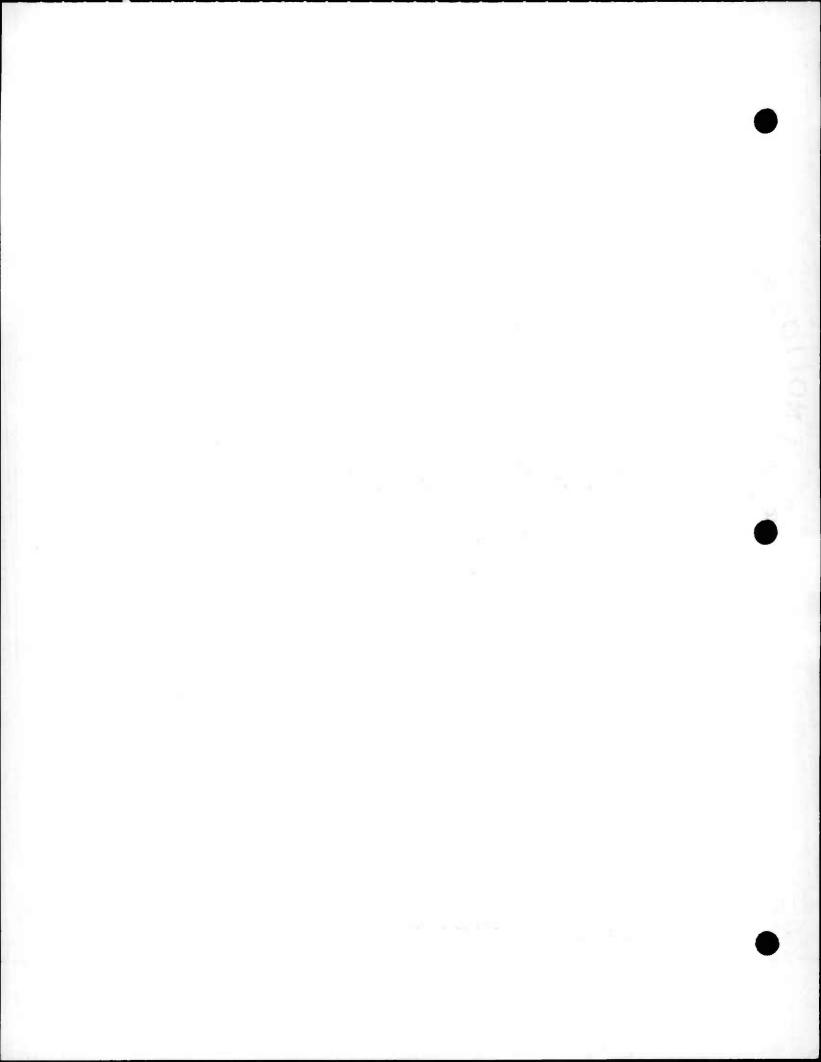
DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with provided and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.

IMPORTANT: It leam 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTRAH		CI	ERITE	CATE	OF DE	AIH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH			TIME OF DEATH
	Thomas Leon	Parke	<u>r</u>					July 16	,	1995 1	1:00 PM M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les		IF UNDER 1 Y		NDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLA	CE (State or Foreign
	215 38 9554	1 XM 2 🗆 F	68	YRS.	MONTHS D	AYB NOU	RS MIN.	Feb. 2, 19	927	Mary1	and
	8a. FACILITY NAME (If not Institution, give st	reet and number)			96. CITY, TO	WN OR LO	CATION OF D			NTY OF DEATH	
5	Bowie Medical Ce	nter			Bot	√ie			Pri	nce Ge	orge's
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	,		La ami							
DIRECTOR			1	l .	TOWN OR L	OCATION				100	I. INSIDE CITY LIMITS?
2	10e. STREET AND NUMBER	e George	S	1	Bowie				,		YES 2 NO
8	12306 Manvel Lan	2				101, ZIP (10g. CITI	ZEN OF WHAT	COUNTRY?
BY FUNERAL	12300 Manvel Lan		T FIFT IN II O A				2071				States
四	1 Never Married 2 2 Married	12. WAS DECEDEN FORCES? 1	YES 2 1	NED NED	It ye	s, specify (Luben, Maxico	NIC ORIGIN? (Specify Yea an, Puerto Rican, etc.)	or No-	14. RACE — / Black, Wi	American Indian, nita, etc.
	3 Widowed 4 Divorced	IF YES, GIVE W	MAR OR DATES		1 🗆	YES 2 🔯	NO Specif	v. No		Specify:	Black
COMPLETED	15. DECEOENT'S EDUC	ATION	16a. OE	CEDENT'S L	JSUAL OCCU	PATION		16b. KIND OF BUS	INESS/INC		Diuck
<u> </u>	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 6 -	l/fe	ive kind of we Do NOT use	ork done durii retired.)	ng most of w	rorking				
릴	12		·	perv	isor			Dept. c	f Pu	blic W	lorke
ğ	17. FATHER'S NAME (First, Middle, Last)					18, 1	AOTHER'S NA	ME (First, Middle, Maiden		DIIC II	OIRD
BE C	Lewis James Park	er				M.	arion	Owens			
10 B	19a. INFORMANT'S NAME (Type/Print)		191	. MAILING	ADDRESS (St			Route Number, City or Town	n, State, Zip	Code)	
=	Barbara Parker		1	2306	Manve	1 La	ne Bo	owie Maryla	ınd	20715	
	20a. METHOD OF DISPOSITION 1)□SBuriel 2 □ Cremetion 3 □ Remo	wal from State	20h PLACE	NDDATEO	E DISPOSITIO	N /Nome of		202 10	CATION	City or Town,	Stata
	4 Donation 8 Other (Specify)		_ Maryl	and T	Jetera	ins C	emeter	cy 7/20/95	Che	ltenha	m Md.
	21. SIGNATURE OF FUNERAL SERVICE LIC			7	22. NAR	IE AND AD	DRESS OF FA	CILITY			
	KOVERT E.	Clar	20. t	200				ns Funeral Lis Rd. Bow			
	23. PART I. Enter the diseasee, or c	omplications the	t caused the de	eth. Do no	ot enter the	mode of	dving, auc	th as cardiac or resoi	ratory arr	est.	Approximate
	ahock, or heert fallure. I IMMEDIATE CAUSE (Final	List only one cau	se on each line	- 1					,		Interval Between
	disease or condition	Pulm	Model	הם להם	20.40					i	Onset and Death
ı	resulting in death)	DUE TO	ION AS A CONSEC	DUENCE OF	-	-	٦.				Pror.
z		Consa	a tribe	R	ent	b	rely	ve-		1	HUN
은	Sequentially list conditions, if any, leeding to immediate	DWE TO	OR AS A CONSEC	DUENCE OF	11	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				7713.
2	cause. Enter UNDERLYING CAUSE (Disease or Injury					9					
E	that initieted events resulting in deeth) LAST	DUE TO	(OR AS A CONSEC	WENCE OF	5						
CERTIFICATION	Teadming in death) CAST										
	PART II. Other eignificant conditions	contributing to	death but not re	esulting in	the under	lvina ceu	se alven in	Part I. 24s. WAS AN	AUTOPSY	24b. WFR	RE AUTOPSY FINOINGS
EDICAL	Chronce o	between	tare, 1	0 11	www	des	01 - O	PERFOR	MED?	AVAI	LABLE PRIOR TO
8				W-01		0003	20032	1 🗆 YES 2	NO		DEATH?
2	DID TOBACCO USE CONTR	PIRLITE TO CA	LISE OF DEA	TH YES		U	NCERTAII	NI TO		1 -	YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	IDOIL TO CA			(Check only		NCERIAII	N A I			
SS	EXAMINER?	HOSPITAL:	CYC-4		OTHER:		(
Ħ	27. MANNER OF DEATH	26s. DATE OF	INJURY	28b. TIME	OF 28c	INJURY A		8 Other (Specify) 28d. DESCRIBE HOW II	JURY OCC	CURED	
	1 Natural 5 Pending investigation	(Month, Di	my, Year)	INJU		WORK?	2 🗌 NO				
BY	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE O	F INJURY — At hor	me, ferm, atı	reet, tectory,			281. LOCATION (Street a	nd Number	or Rural Route	Number.
COMPLETED	4 Homicide determined	building,	etc. (Specify)					City or Town, State)			
١٣	29a. CERTIFIER CERTIFYING PHYSIC	CIAN: To the best of	my knowledge de	th occurred	at the time	data and a	and due	to the cause(a) and man			
ž I	(Check only one) 2 MEDICAL EXAMINER										manner on stated
	296. SIGNATURE AND TITLE OF CERTIFIER										
H H	K Come last	10	INTE	PALIC	7	29c.	LICENSE NUI	MBER /	29d. DATE	SIGNED (Mon	oth, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALIS				_ -	29/3			1-18	5-75
	KADVIE I FA	CH N			ANN	HAPN	10 1	DAT	Na Vil.	Λ ΛΛ A.	100000
	31. DATE FILED (Month, Day, Year)	82 REGISTRA			1000	41 11 OF	73 14	a 11 La	HUH	41111	Nd 20706
	JUL 19 1995	false de	R'S SIGNATURE	Щ							1
		L/									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

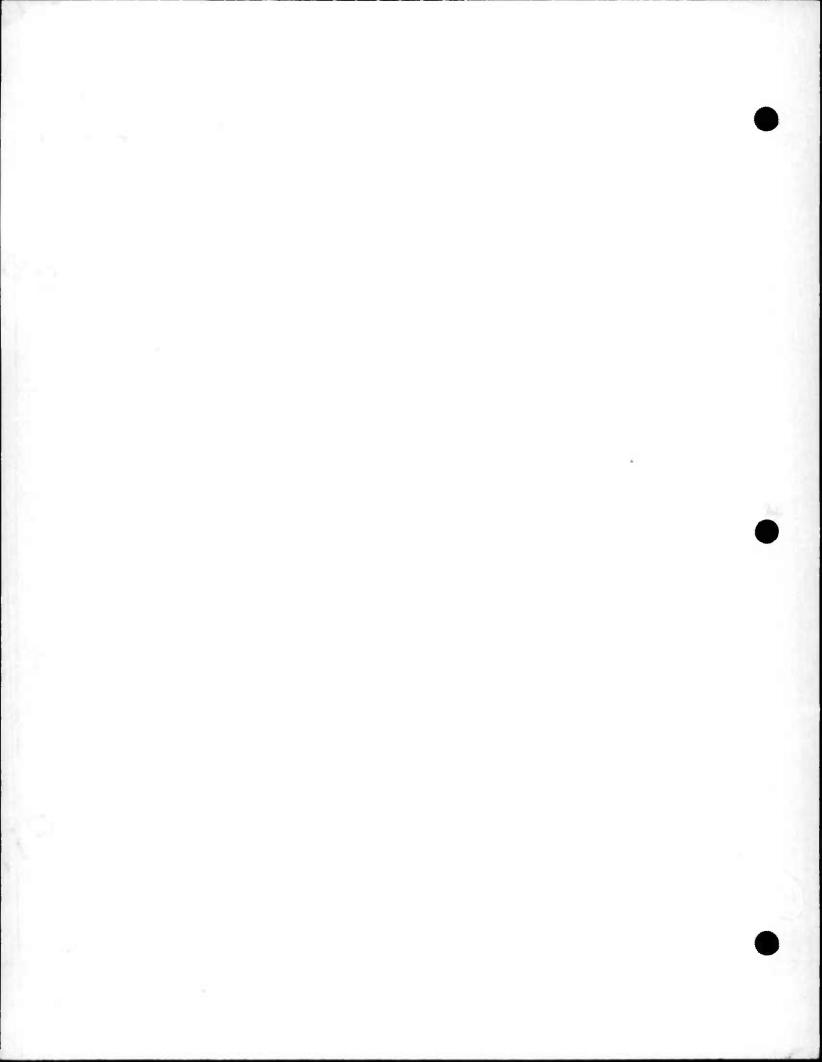
FOR 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

-	NEGISTRAN			CENTIF	ICALL	E OF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)							2. 0	ATE OF DEATH	Y	YEAR	3. TIME OF DEATH
	CLIFFORD	ANTHO	VY P	OWELL					ILY 15	, 19	995	0155 A M
	4. SOCIAL SECURITY NUMBER	5. SEX		s. lest birthday)	IF UNDER		IF UNDER 24 HRS.	7. D.	ATE OF BIRTH		Country	PLACE (State or Foreign
	218-98-0423	1X□ M 2 □ F	23	YRS.	MONTHS	DAYS	HOURS MIN.	NĈ	V. 13, 1	971	ENGL	EWOOD, NJ
	9e. FACILITY NAME (If not institution, give st	reet end number)			96. CITY	r, TOWN	OR LOCATION OF E	_		9c, COU	NTY OF DE	EATH
OR	PRINCE GEORGE'	S HOSPI	TAL C	CTR.	C	HEV	ERLY			PR:	INCE	GEORGE'S
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			T								
E	20000000	CE GEOR	anic		Y, TOWN		TION				- 1	10d. INSIDE CITY LIMITS?
- 1	MARYLAND PRIN	CE GEUR	GE S	B	WIE							1 X YES 2 NO
FUNERAL	12711 HASKI	ETT TAN	T.			10	1. ZIP CODE 20716			-		HAT COUNTRY?
y.	11. MARITAL STATUS	12. WAS DECEDEN									JSA	
	1XXNever Merried 2 Merried	FORCES? 1	YES 2	XNO		If yes, so	CENDENT OF HISPA pecify Cuben, Mexic	en. Pue	IGIN? (Specify Yee rio Ricen, stc.)	or No	Black	- American Indien, , White, etc.
à	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES			1 TYES	2 NO Spec	lly:			Specif	BLACK
	15. DECEDENT'S EDUC	CATION	18e	. DECEDENT'S	USUAL O	CCUPATI	ON	T	16b. KIND OF BUS	INESS/INI	DUSTRY	
FI	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	-)	(Give kind of life. Do NOT u	work done se retired.)	during m	ost of working	- 1				
릴	12th			PRIVE	TE	CON	TRACTO	R		PVT.	•	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				-				rst, Middle, Meiden S	Sumame)		
BE C	CLIFFOR	D E. PO	WELL					AL	DA V.	RHON	VE	
10 B	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRES	S (Street	and Number or Rural	Route I	lumber, City or Town	, State, Zip	Code)	
F	CLIFFORD POWE		HER	12711	HA	SKE	LL LAN	Е В	OWIE.	MARY	LAN	D 20716
	20a METHOD OF DISPOSITION 2 Buriel 2 Cremetion 3 Remo	uml from State	20b. PLA	CE AND DATE	OF DISPOS	SITION (N	ame of		ATE 20c. LOC	ATION -	City or Toy	vn. State
	4 Donation 5 Other (Specify)		HAR	MONY	MEM	ORI	AL PARI	χ 7.	-22 - 95 L	ANDO	VER,	MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	0.	. 1	22.	NAME A	ND ADDRESS OF F	ACILITY				
	Valvan	a H.	Ma	KLOY		474	LANDOVE	R	DAD LAND	OVER	, MAI	20785 RYLAND
1	23. PART i. Enter the diseases, or c ahock, or haert failure. I	omplications tha	t ceused the	death. Do	not enter	the mo	ode of dying, au	ch as	cardiac or reapir	atory an	rest,	Approximate
-	IMMEDIATE CAUSE (Final	and only one ode	or on each									intarval Between Onset and Death
	disease or condition resulting in death)	N	ECK I	NJURY								
		DUE TO	(OR AS A COA	NSEQUENCE O	F):							
z I	Sequentially list conditions,											
CERTIFICATION	if any, leading to immediata cause. Enter UNDERLYING	DUE TO	(OR AS A CON	ISEOUENCE O	F):							
5	CAUSE (Disease or injury	DUE TO	(OR AS A CON	PEOUENCE O								
	thet initieted events resulting in deeth) LAST	DOE 10	(OR AS A CON	ASECUENCE O	-):							
	-											-
	PART ii. Other aignificent conditions	s contributing to	deeth but n	ot resulting	in the ur	nderlyin	g cause given in	Part I	. 24a, WAS AN			WERE AUTOPSY FINDINGS
EDICAL									PERFORI			AVAILABLE PRIOR TO COMPLETION DF CAUSE
ME												OF DEATH? 1 💢 YES 2 □ NO
	DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF D	EATH YE	S 🗆 I	NO [UNCERTAI	N \square	ıl .			
ኟ▮	25. WAS CASE REFERRED TO MEDICAL		28. P	LACE OF DEA	_							
ž I	EXAMINER? 1 (2) YES 2 NO	HOSPITAL:	ER/Outpatien	R 3 DOA	OTHER		ne 5 🗆 Residence	8 🗆 0	Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF (Month, D	INJURY	28b. TIM		28c. IN.	IURY AT	28d.	DESCRIBE HOW IN	JURY OC	CURED	73 77 77 77 77 77 77 77 77 77 77 77 77 7
BY	1 Netural 5 Pending Accident Investigation	7/14/		11:	33		YES 2 X NO		IVER OF JECT COI			FIXED
	3 Suicide s Could not be	28e. PLACE O	F INJURY — A			lory, offic	•	28f. I	LOCATION (Street ar	nd Number	or Rural Ro	oute Number,
	4 Homicide determined		FF STR	EET				90	00 BLK F	RACE	TRAC	K BOWIE MD
COMPLETE	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of	my knowledge	, death occurr	ed at the t	ime, date	end place, and du	to the	cause(e) and many	ar en etel	ad	
Ž	one) 2 XX MEDICAL EXAMINER											end menner ee stated.
- 111	29b. SIGNATURE AND TITLE OF CERTIFIER											
#	Nouged II (1)	right 1	UD				O.C.M.H		1			(Month, Day, Year) , 1995
일	30. NAME AND ADDRESS OF PERSON WHO			(ITEM 27) /7/00	Print)		U.C.IVI.	•		- 00	LA IO	, 1333
	DONALD G. WRIGH					ET :	BALTIMORE,	MAI	RYLAND 21	201		
	31. DATE FILED (Month, Day, Year)	32. REGISTRA	R'S SIGNATUR	Parl-11								
	JUL 20 1995	James W	- Magninum	ARCON !								

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DHMH-16 Rev 1/89



Pages 1, 2, 3 should funeral director, page 5 should be detached for use as the burial-transit permit, hours after death, Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 n by the fi filled in by t 0 completely filled rial, cremation, c executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760 and com signed by the attending physician a Health and Mental Hygiene prior to

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH John GNE 26 YEAR 1850 A PALMER 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign Country) 1929 213 24 0875 1 M 2 | F 202 DAYS HOURS May 2, Maryland 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF GEATH DIRECTOR Veterans Medical Center Baltimore Baltimore 10b. COUNTY 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Talbot McDaniel 1 YES 2 XNO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9618 New Road 21647 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11, MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Maxican, Puarto Rican, etc.)

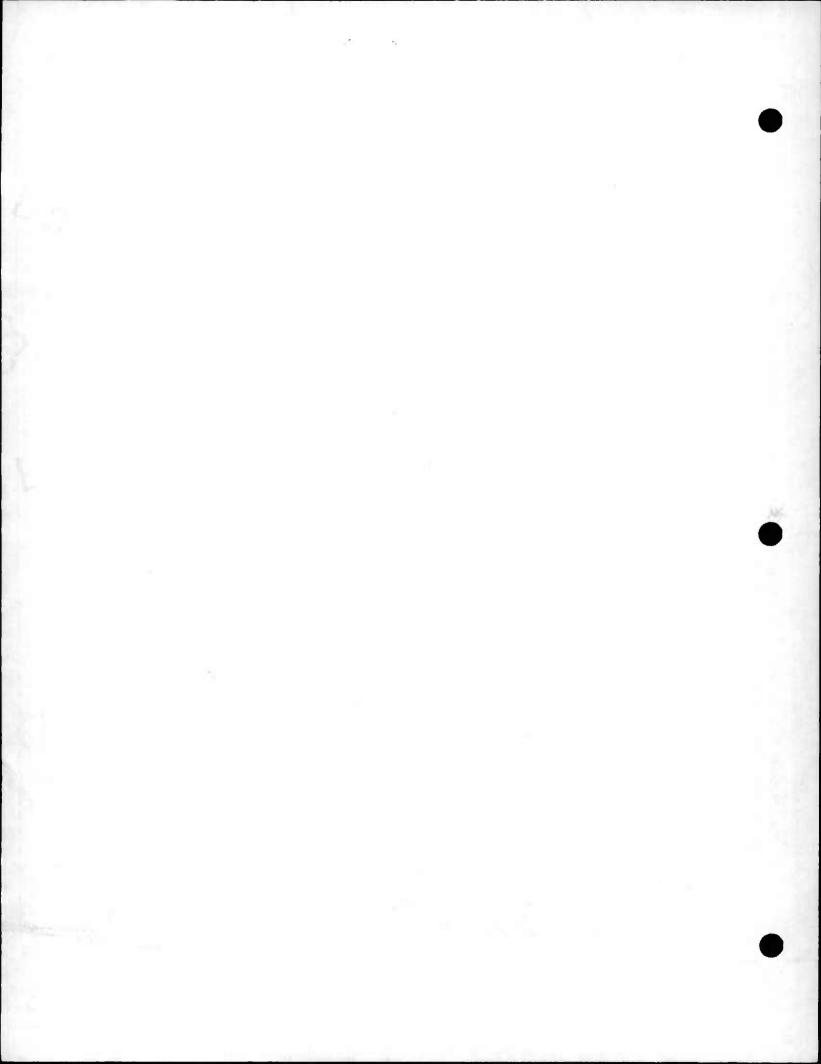
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, stc. 1 Never Married 2 Married BY Specify: Black 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ndary (0-12) College (1-4 or 5 +) 10th Waterman Seafood 17. FATHER'S NAME (First, Middle, Leel) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Eugene Palmer, Sr. Mariam Lee Cooper BE notified a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jonathan Palmer 6061 Hunter's Mill Dr., Salisbury, Md. 21801 Pe 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Thomas Memorial Cemetery 7/5/95 Donation 6 - Other (Specify) St. Michaels, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LIDENSEE 22. NAME AND ADDRESS OF FACILITY Bennie Smith Funeral Services P.O. Box 1687, Easton, Md. 21601 medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory erreat, shock, or heert feliure. List only one cause on each line. Approximets Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disesse or condition reaulting in death) DUE TO (OR AS A CONSCOUENCE OF): other traumatic event, chest mass/probable lung CA CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be ID THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traur enronic obstructive CAUSE (Diseese or Injury OUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in desth) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES, NO UNCERTAIN PHYSICIAN: 25. WAS CASE RESERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPIFAL: OTHER: 1 YES 2 NO 1 Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT 26b. TIME OF 26d. DESCRIBE HOW INJURY OCCUREO 1 Natural 5 Pending Investigation BY 1 YES 2 NO Accident 3 Suicida 26a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 6 Could not be 4 🔲 Homicide 29a. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. COMPL 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE THON CLOSES- BLOS 06/26/95 2 0. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREEN BALTIMORE 2120

82 REGISTRAM'S SIGNATURE

31. DATE FILED (Month, Day, Vent)

JUN 3 0 1995



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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) KATHLEEN 2. DATE OF DEATH 3. TIME OF DEATH VO TTER JULY LEAH 0.300 krs H 7. DATE OF BIRTN
(Month, Day, Year)

JUNE 22 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 🗆 M 2 😾 F 216-17-7430 19 VRS 1976 MARYLAND Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR U. OF MD./SHOCK TRAUMA BALTIMORE BALTIMORE RESIDENCE OF DECEDENT JOb. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND **QUEEN ANNE'S** QUEENSTOWN 1 YES XXNO permit. FUNERAL 10a, STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 1110 BLOOMINGDALE ROAD 21658 USA retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexicen, Puerto Ricen, stc.)
 I YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried Specify: WHITE BΥ 3 Widowed 4 Divorced ISO. DECEDENT'S USUAL OCCUPATION

Third of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) PROSPECT BAY COUNTRY College (1-4 or 5+) 12 WAITRESS CLUB 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) 듉 RICHARD K. POTTER KAYE WALLS BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 RICHARD K. POTTER 1110 BLOOMINGDALE ROAD, QUEENSTOWN, MD hours after death. Page 6 may be 20e. METNOD OF DISPOSITION
1 XBuriel 2 Cremetion 3 Removal from Stale
4 Opnetion 5 Other Occurs pe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must WOODLAWN MEMORIAL PARK 7-18 Ognetion 5 - Other (Specify) _ EASTON, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY NEWNAM FUNERAL HOME, P.A. JOHN TZ. 200 S. HARRISON ST., EASTON, MERCERON CFSP completely filled in by the the medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiac or reapiratory arreat, Approximate ahock, or heart fallure. List only one cause on each line. Interval Between cremation, or Onset and Death **IMMEDIATE CAUSE (Final** HEAD INJURY (SEVELE) & CRESHAL

A CONSEQUENCE OF:

A CONSEQUENCE OF:

A CONSEQUENCE OF:

D C.-APPROVED-OCHE disease or condition resulting in death) CLOSED 3hrs event, DUE TO (OR AS A CONSEQUENCE OF): the attending physician and con Mental Hygiene prior to burial, traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF) cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE CONTUSION (MASSIVE 23 shows any 1 TYES 2 NO OF DEATN? PRACTURED 1 - YES 2 10 has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? L DIRECTOR: After this certificate had 2 hours after death with the State Dk if item 28 is marked, or item 2 26. PLACE DF DEATH (Check only one) ATTENDING PHYSICIAN: The HOSPITAL: OTHER: 1 TYES 2 NO Inpetient 2 ER/Outpetient 3 DOA 4 ☐ Nursing Nome 5 ☐ Residence 8 ☐ Other (Specify) 28a. DATE OF INJURY (Month, Day, Ibar) 28b. TIME OF INJURY WOR 1 UP Y 28b. PLACE OF INJURY — At home, farm, street, lactory, office building, etc. (Specify) 27. MANNER OF DEATN 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Netwril
2 Accident MOTOR VEHICLE COLLIFION 1 YES 2 NO BY Investigation 281. LOCATION (Street and Number or Rural Route Number, 3 Suicide COMPLETED 8 Could not be 4 Nomicide ASTON MARYLAND STURET. HOSPITAL DR 29e. CERTIFIER ** CERTIFYING PNYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. TO THE HOSPITAL ITO THE FUNERAL DID BE filed within 72 hr (Check only one) MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) and menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE ► July 13. 1995. 2 D ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) STC USIMO 225 GREENE SZ REGISTRAR'S SIGNATURE

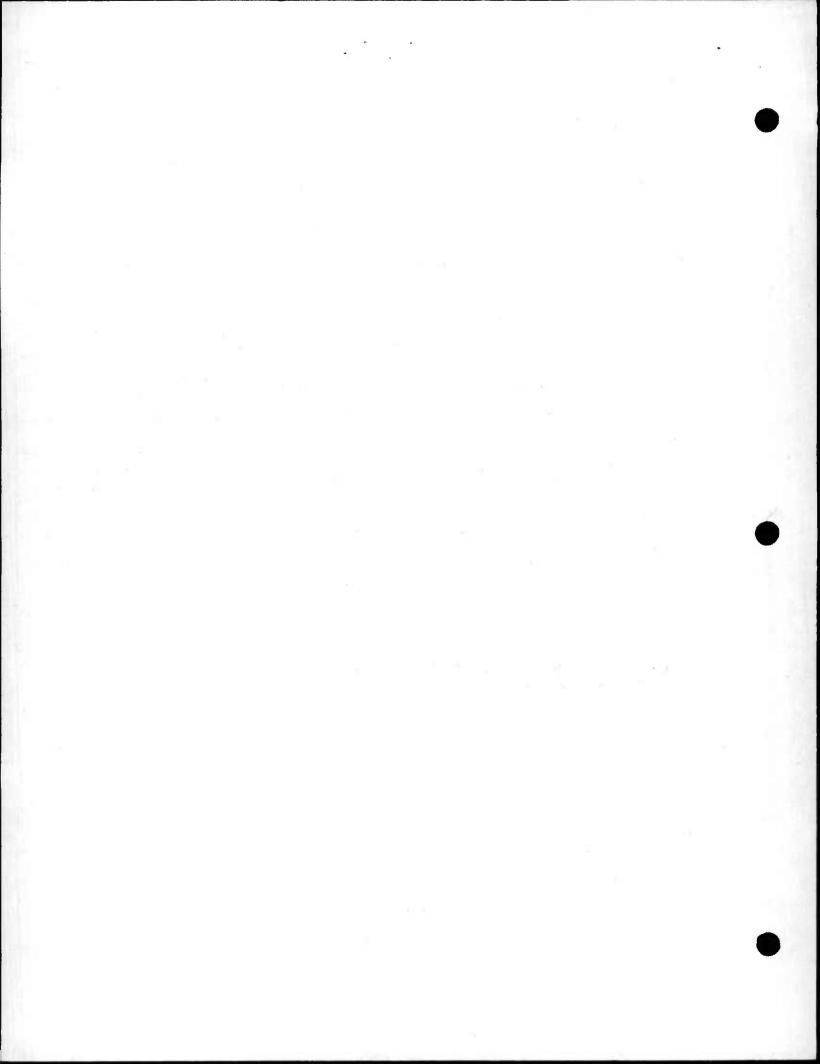
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-16 Rev 1/89

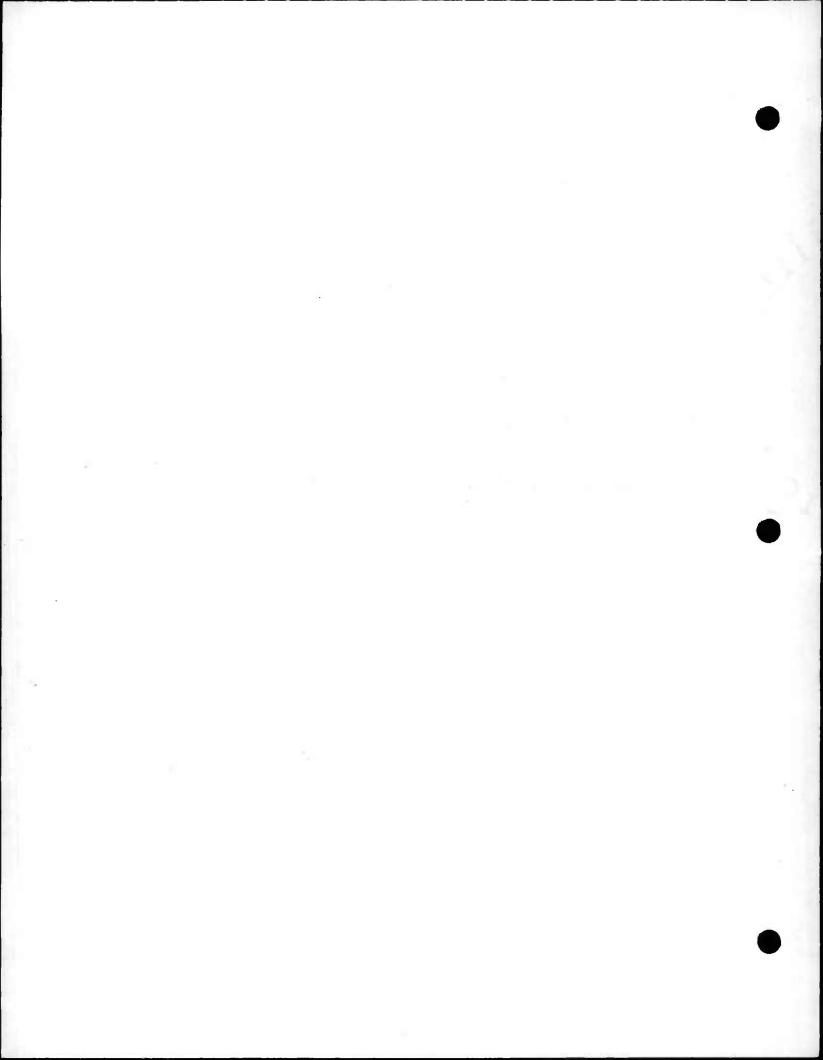
programme of the contract of t AND A SHOP OF SHIP SHIP FOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760 B BALTIMORE, MARYLAND 21215-0020

		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
		1. DECEDENT'S NAME (First, Middle, Last)			TOMIL O	DEALL	2. DATE OF DEATH	/ /	3. TIME OF DEATH	
		Russell B. P.	ilchard, Jr.				July 10	AY 1995	AR .	
		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year)	14 8. Bt	RTHPLACE (State or Foreign ountry)	
₽		216-14-9212	1 KM 2 F	72 YRS.	MONTHS DAY	8 HOURS MIN.	06/14/2	_	arvland	
3 should	_	9a. FACILITY NAME (If not institution, give :				N OR LOCATION OF D		9c. COUNTY O	OF DEATH	
۲۵	DIRECTOR	Deer's Head Center				Salisbury Wicomico				
	EG	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y	10c. CIT	Y, TOWN OR LO	CATION			10d, INSIDE CITY	
r. Pag	昌	Md. Wo	rcester						LIMITS?	
ermit		10e. STREET AND NUMBER	TCEBCET		GIL	dletree		10a. CITIZEN C	1 YES 2 NO	
usit p	ER	Rt. 12				21829				
ending physician. as the burial-transit permit. Pages 1,	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER		13. WAS D	ECENDENT OF HISPA	NIC ORIGIN? (Specify Yes	U.S. 1 or No.— 14. B	IACE — American Indian.	
e bu	BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 X YES		It yes,	specify Cuban, Maxica ES 2 K NO Specif	n, Puarlo Rican, etc.)	B	Black, Whita, atc.	
attending ise as the			W.W.II	1					white	
a ag	PLETED	15. DECEDENT'S EDU (Specify only highest grade	e completed)	16a. DECEDENT'S (Give kind of	USUAL OCCUPA work done during se retired.)	NTION most of working	16b. KIND OF BUS			
pital of for		Elementary/Secondary (0-12)	College (1-4 or 5+)				Nation	al Aer	onautics	
the hospital or detached for u	COMPL	17. FATHER'S NAME (First, Middle, Last)		40202	pace		ME (First, Middle, Maiden		ministratio	
2 2 E	C	Russell B. Pi	Ichard, Sr	•		1				
retained to 5 should notified	00	19a. INFORMANT'S NAME (Type/Print)	Tellara, Dr	19b. MAILING	ADDRESS (Street	IMartna	Rew Pile Route Number, City or Tow	chard	1 - 0 - 0 - 0	
_ co _ E	2	Russell B. Pi	lchard, II				anton Rd			
may be or, page		20a. METHOD OF DISPOSITION	20	b. PLACE AND DATE	OF DISPOSITION			CATION — City o		
9 e e		1 ♥ Buriet 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	S	metery, crematory or o		metery	7/15 Gi			
death. Page funeral direct. L.		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		AND ADDRESS OF FA	CILITY			
death. funera i.		Fatricia Lennis Dennis Funeral Home, Md. 21863								
after nova		23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate								
D D D E		shock, or heart failure. IMMEDIATE CAUSE (Fins)	List only one cause on a	aach iina.			11 60 001 1100 01 100	interip arrows,	intarvai Batween	
E = 5 P		disease or condition Find stage renal disease							Onset and Death	
8 5 3 6		resulting in death)		A CONSEQUENCE O					-	
	z	Polycystic kidney Lifetime								
ertificate be executing physician and cigiene prior to burian other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE O	F):					
ficate be physician ne prior t	2	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								
nding phy Hygiene or other										
	병	d								
in the	CAL	PART ii. Other significant condition					Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS	
- 9 E 6		Rectal bleeding	secondary to	o AV malf	formation	on	1 YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
requires the been signed of Health s	ME	Carcinoma prostate								
> 0 = -	ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								
H ste H	PHYSICIAN: MEDI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? A CONTROL OF DEATH (Check only one) OTHER:								
SICIAN: The certificate to the State	ΥS	1 D YES 2 XNO	1 1 Inpatient 2 ER/Out		4 - Nursing H	ome 5 - Rasidence	6 Other (Specify)			
this with		27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)		IURY \	NJURY AT WORK?	28d. DESCRIBE HOW II	NJURY OCCURED		
After death	ВУ	2 Accident Investigation	26. DI ACE OF IN HID	Y 44 home from 1		YES 2 NO				
TTEND TOR: / after d	ED	3 Suicide 6 Could not be 4 Homicide detarmined	26a, PLACE OF INJURY building, atc. (Spe	r — at nome, tarm, s ecify)	street, tactory, or	Tica	28t. LOCATION (Street a City or Town, State)	nd Number or Rur	ral Route Number,	
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	COMPLETED	29a. CERTIFIER X								
로기도도	MP	(Check only 12) CEHTIFTING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) and manner as stated,								
THE HOSPITAL THE FUNERAL I filed within 72 h		2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.								
TO THE HOSPIT TO THE FUNERA Be filed within 7 IMPORTANT: I	BE	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUM		~ ~ /		IED (Month, Day, Year)	
2 6 5 ₹	2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	FATH (ITEM 27) (See	Oninot)	D33905		//	10 95	
		30. NAME AND ADOPESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
	5	Virginia A. Dulany, M.D., CMD, P.O. BMOX 2018, Salisbury, MD 282802-2018 31. Date Filed (Month, Day, Year) 32. REGISTRAR'S SIGNATURE								
		JUL 14 1995	Jalia Danie	Randall						
			7.5							



		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEP	ARTMENT	OF HEALTH	AND MI	ENTAL HYGIEN				
	1	1. DECEDENT'S NAME (First, Middle, Last) RICHARD	С.		DOLLAR		- 1	DATE OF DEATH	MY	YEAR 3, T	IME OF DEATH	
	3	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthde	POLLA			JULY 23,	1995		:37A	М
pinous		082-30-3153 9e. FACILITY NAME (If not institution, give	1 K M 2 🗆 F	57 YRS	MONTHS .	DAYS HOURS	MIN.	Month, Day, Year)	(Country) Cayuga		
co co	J. L	THE JOHNS HOPE				SALTIMOR				y of death		
3 1, 2,	ЕСТО	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT							Dur	PIMOL		_
permit. Pages	DIR	PA F	ranklin	- 1	arv, rown o aynesb						INSIDE CITY LIMITS? YES 2 NO	
sit	FUNERAL	307 Reservoir				10f. ZIP CODE	17268	3	10g. CITIZE	N OF WHAT		
21215-0020 al or attending physician. for use as the burial-transit	B≺	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? NO YES IF YES, GIVE WAR OR D KOrea & Vie	2 NO	11	AS DECENDENT O yes, specify Cuber YES 2 X NO	n, Mexicen, I	ORIGIN? (Specify Ye Puerto Ricen, etc.)	e or No-	Black, Wh	white White	
215 atten	9	15. DECEDENT'S EDI (Specify only highest grad	CATION	16a. DECEDEN	T'S USUAL OC	CUPATION uring most of working	a	18b. KIND OF BU	ISINESS/INDUS	STRY		_
D 21, pital or ed for u	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NO	T use retired.)		9	II C A				
YLAND 2 by the hospital be detached to at once.	OM	17. FATHER'S NAME (First, Middle, Last)		Soldi	er	18 MOTH	IFR'S NAME	US Ar				_
YL, by the of the of	BE C	Henry Charl	es Pollard				tha	Watkins	Surremey			
, MARYLAND 2121 be retained by the hospital or ath e 5 should be detached for use notified at once.	TO B	196. INFORMANT'S NAME (Type/Print) Mary Lou Pollard					or Rural Rou	te Number, City or Tow	n. State, Zip Co			
RE, may be or, page		20s. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Ran		PLACE AND DA	TE OF DISPOSIT		,,a,		CATION - CIT		itete	
MOR age 6 mar director, p		4 Donation 5 Other (Specify) 21. SIGNATURE @F FUNERAL SERVICE_L	St	Andres	v s Cer	netery		26 Way	nesbor	o, PA	17268	
SE BALTIMORE, MARYLAND urs after death. Page 6 may be retained by the hospit in by the funeral director, page 5 should be detached removal. Ledical examiner must be notified at once.		Domes ()	Dor Jersey					"Grove F Waynesb				
nours after d in by the or removal medical		23. PART I. Enter the diseases, or	complications that cause List only one cause on e	d tha death. D	D not antar t	he mode of dyle	ng, such a	s cardiac or resp	Iratory arrea	t,	Approximate	_
FBOF		IMMEDIATE CAUSE (Fine)			,					į	Onest and Des	
tely math		disease or condition resulting in death)	. Lactic	Acido:	212						1 day	1
	_		DUE TO (OR AS A								10 1	
	5	Sequentially list conditions, if any, leeding to immediate	DUE TO (OR AS A	CONSEQUENCE	OF):						10 day	5
BOX cate be e hysician prior to	CA	cause. Enter UNDERLYING CAUSE (Disease or injury	· Aplastic	Anemio							1 mo	a
certificate ding physical professional contracts of the contract of the contra	RTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE	OF);							
DS, P. the death c the attendi Mental Hy njury, or	CE		d									
and the man of the man	DICAL	PART II. Other significent condition	na contributing to death b	out not reaultin	g in the und	arlying ceuse g	Ivan in Pa	1 YES 2	RMED?	COM	E AUTOPSY FINDING ABLE PRIOR TO PLETION OF CAUSE EATH?	S
w requires the been signed pt. of Health 3 shows an	MEDI										YES 2 NO	
S e as a	Ä	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL					ERTAIN					
	PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL:	26. PLACE OF D	OTHER:							_
SICIAN: The certificate in the State id, or item	H	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. 1	TIME OF 2	ng Home 5 - Res		Other (Specify)	NJURY OCCUP	RED		
ON ON ON ON ON ON ON ON ON ON ON ON ON O	ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)		M	WORK?	NO			-		
TTENDI TTOR: A after do		3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, fern	n, atreat, fector	y, office	26	Rt. LOCATION (Street of City or Town, State)	and Number or	Rural Route I	Number,	
L OR A Phours them	COMPLET	29e. CERTIFIER (Check only 1) CERTIFYING PHYS	CIAN: To the best of my know	ledge, death occi	urred at the tim	e, data end piece,	end due to	the ceuse(e) end mer	nner ee atated.			
THE HOSPITAL THE FUNERAL filed within 72 i	NO.		R: On the baels of examination							ause(e) end	menner ee stated.	
TO THE HOSPITA TO THE FUNERA DE filed within 7 IMPORTANT: 1	BE C	296. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICEI	NSE NUMBE	R	29d. DATE S	IGNED (Mont	h, Day, Year)	_
5 5 3 W	5	mathew	F. Malti	MO		^	126	38	> 7/	23/9.	5	
		30. NAME AND ADDRESS OF PERSON WE MATTHEW J. WALTE	R, 2027 GO	rugh st		HMORE,	mo	21231				
		31. JUI 2 5 1995 A	A REGISTRAR'S SIGN	ATURE ALL,								



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M	requires that the death certificate he executed within 74 hours after death. Page 6 may he retained by the hour
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RECORDS, P.O. BOX 68760	MACI
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detached for use as the burial-transit permit. pital or attending physician. pe page 5 should funeral director, n by the 1 removal. filled in t 0 cremation, and completely for burial, cremation 9 the attending physician Mental Hygiene prior to and t signed Health a been it. of h has b. Dept. certificate h OR ATTENDING PHYSICIAN: this c After 1 death DIRECTOR: A FUNERAL within 72 h HOSPITAL 표

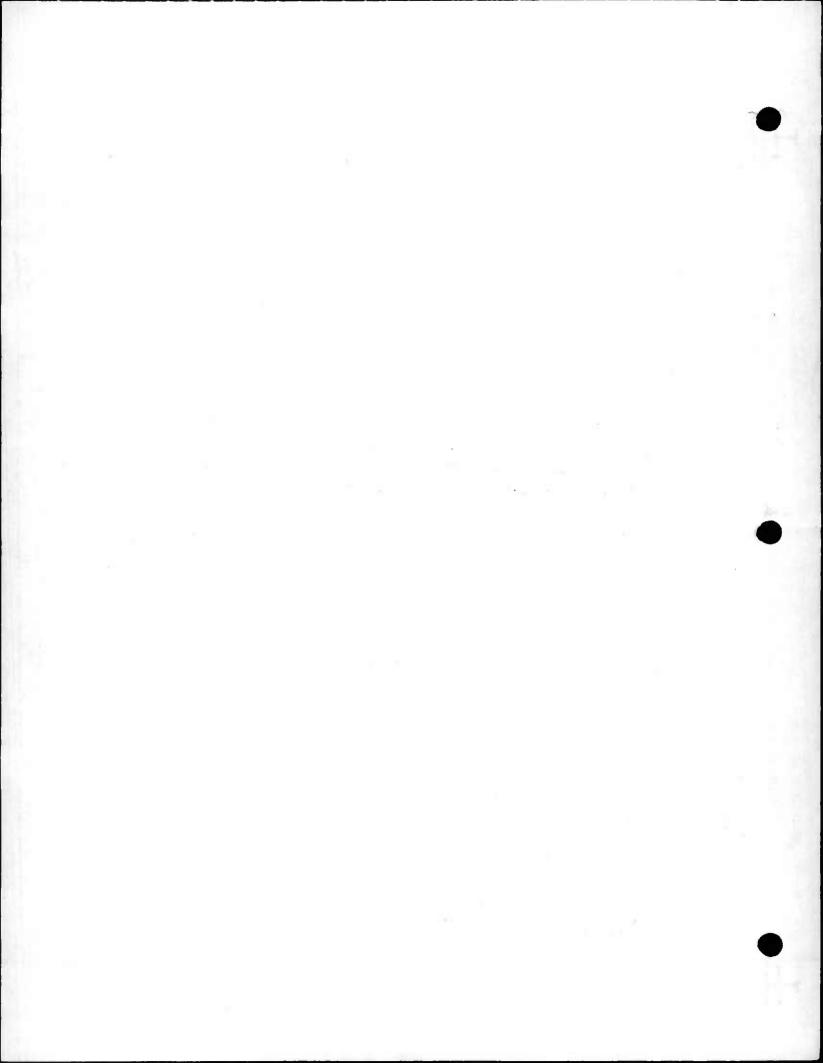
Pages 1, 2, 3 should

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH THELMA TUCKER RAMSEY JULY 13, 1995 12:15A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 254-30-8155 81 February 26, Georgia 9e. FACILITY NAME (If not institution, give street and number 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Prince George's Hospital Center Prince George's Cheverly 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Capitol Heights Prince George's 1 X YES 2 | NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 133 Maryland Park Drive 20743 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexicen, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried BY 1 TYES 2 TYNO Specify: Specify 3 Widowed 4 Divorced Black 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 8th Cafeteria Worker Private 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) To Richard Tucker Lula Roberts BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 133 Maryland Park Dr., Capitol Heights, MD 20743 Jessie T. Graham pe 20a. METHOD OF DISPOSITION 1 S Buriet 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specific) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Cametery, crematory or other placel
Lincoln Memorial Cemetery 7/20/95 Donation 5 Other (Specify) Suitland, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 medical 23. PART I. pager the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximate k, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death the diseese or condition severe Conses time event, t recuiting in death) me 2119 traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING dua CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events regulting in death) LAST 0 injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? van Ced He 100 0 PERFORMED? shows any 1 TYES 2 NO 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL 1 TES 2 NO Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending BY 1 YES 2 NO 2 Accident 26e. PLACE OF INJURY — At home, farm, street, fectory, office building, stc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Sulcide .09 COMPLETED 6 Could not be 4 Homicide 28 IMPORTANT: If item 29e. CERTIFIER

(Check only

One)

2 MEDICAL EXAMINER: On the best of examination end/or investigation, in the control of the cause (s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piecs, end due to the ceuse(e) and menner ee stated. SIGNATURE AND TITLE OF CERTIFIE 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

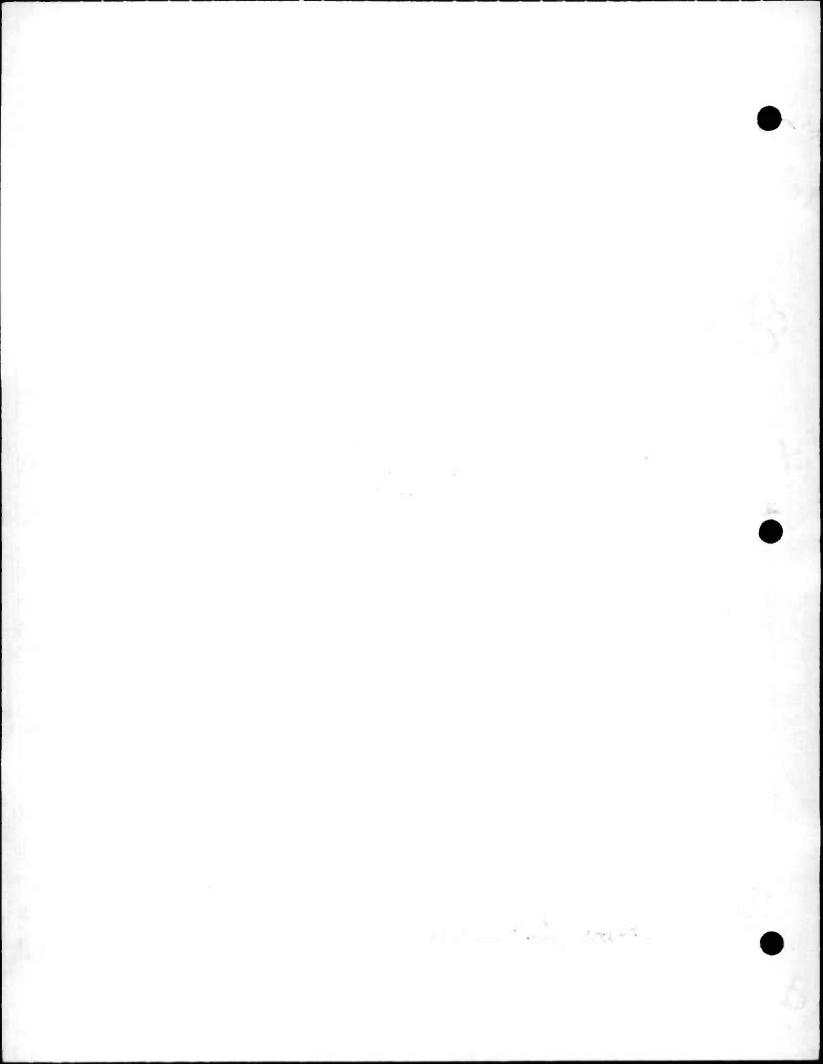


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1 - FOR STATE REGISTRAR

		1. DECEDENT'S NAME (First	t. Middle, Last)								2. DATE OF DEATH	-		3. TIME OF DEATH
		Elizabeth		D.	chardso	n					MONTH	DAY	YEAR	
		4. SOCIAL SECURITY NUM		5. SEX	6. AGE (In yrs. In:		IE LINDE	R 1 YEAR	IF UNDER	24 MDC	July 7. DATE OF BIRTH	L5 199		4:20 P M PLACE (State or Foreign
		247-46-844	. 2	1 M 2 F		YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	1020	Country	1)
pinous		9e. FACILITY NAME (If not in		1	65		ah cor	V TOWN C	OR LOCATI	ON OF O	March 30,	_		uth Carolina
2, 3 shr	DIRECTOR	Washingt	on Adv	entist H	lospital		90. CIT		akoma			9c. COI	Mont	gomery
, `	5	RESIDENCE OF DEC												
Pages	뿔		10b. COUNTY			10c. C/1	Y, TOWN	OR LOCAT	TION					10d. INSIDE CITY LIMITS?
permit.		Maryland		ince Geo	rge's	<u> </u>			idove					1 X YES 2 NO
	₹	10e. STREET AND NUMBER						101	. ZIP COD		_			HAT COUNTRY?
an. ransi	FUNERAL		ntvill	age Plac						2078	55	J	Jnite	d States
20 sysicia	5	11. MARITAL STATUS 1 Never Married 2	Mandad		T EVER IN U.S. AF		13.	WAS DEC	ENDENT C	F HISPAN	IC ORIGIN? (Specify	fes or No-	14. RACE Black	- American Indian, White, etc.
215-0020 attending physician. se as the burial-transit	B	3 Widowed 4 Divo		IF YES, GIVE Y					2 NO				Specif	y:
N S W		15 DEC	EDENT'S EDU	CATION	100 00	CEDENT'S	1101111 6	2010171				Mary September		Black
	ETED	(Specify onl	ly highest grade	completed)	(G	ive kind of Do NOT u	work done	during mo	on St of worki	ng	16b. KIND OF E	IUSINESS/IN	DUSTRY	
of pital of	7	Elementery/Secondary (I	0-12)	College (1-4 or 5	+)							2.7		
the hospital of detached for once.	COMPL	8th 17. FATHER'S NAME (First, N	Aiddle Leet)				Hous	ewif				N/	A	
YL/		The state of the state of		tor Peak	0				18. MO1	TER'S NA	ME (First, Middle, Meid		+ 0 20	
TARY stained b should to	BE	190. INFORMANT'S NAME (tor reak				0.00				Le Fos		
MARYLAND For retained by the hospit S should be detached notified at once.	2	Willie		doon	119						loute Number, City or 7			0705
		20e. METHOD OF DISPOSIT		uson						. LT9	ce, Lando			
e 6 may ector, p		1X Buriel 2 Cremetic 4 Donation 5 Other	on 3 🗆 Reme	oval from State	20b. PLACE cernetery, cre Ft.	metary pro	ther place	Com	nne or	7	/21/95 20c.	OCATION -		od, MD
Page al direc		21. SIGNATURE OF FURERA		CENSEE 4		• 1411			ID ADDRE			Dre	HLWO	od, no
BALTIMORE, er death. Page 6 may be the funeral director. page val.	į į	· \ \		4	4-	-		TOTAL PAR	NO ADDITE	33 01 174		vart I	uner	al Home
after de noval.		18/	W	Meli	rank 1	11	_ 4	001	Benn	ing	Rd., N.E.	Wash	1., D	.C. 20019
Nours after d in by the or removal		23. PART Enter the d	liseases, Dr c	complications that List only one cau	t caused the da	ath. Do	not anta	tha mo	da of dy	ng, sucl	as cardiac or rea	piratory sr	rest,	Approximate
		IMMEDIATE CAUSE (FIR			a cit agett inte									Onset and Death
The High		disease or condition resulting in death)	→	. Ac	ute	Kee,	biNO	itau	1	lau	lewe			mouth
	ĺ			DUE TO	(OR AS A CONSE	OUENCE Q	7):		-		-			17712
	Z	Sequentially list condit	ione C		evere	pu	lmo	now	4	lest	enteurá	^		many yrs
× 5 5 5	Ĕ	if any, leading to imme	diata	DUE TO	(OR AS A CONSE	OUENCE O	F):		J	"01	0 ,		2	
	2	cause. Enter UNDERLY! CAUSE (Disease or inju		دک	severc	Mu	wal	81-	euos	0 9	ed breu	efno!	Legery	Halu rangy
O. B. certificat ling phy ygiene p	E	that initiated events resulting in death) LAS	т	DUE 10	D I	DUENCE O	F):	1.0.		D	T 1	1	0	,
, P. eath attendated H	CERTIFICATION			d	Muler	nau	el	our	illa	N W	east d	LSROV	10	
DS, the dead of Ment injury,	- 4	PART II. Other significa	int condition	s contributing to	death but not r	eauiting	in the u	ndarlying	cause g	iven in	Part i. 24a, WAS	N AUTOPSY	24b.	WERE AUTOPSY FINDINGS
that had had had had had had had had had had	ICAL	Septie.	stive	< Aeud	e sanal	fai	leue	· Hu	ylen	leue	1 PERF	DRMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
O 5 5 5 8		unti He		Angen		ard					1 1 123	20,00		OF DEATH?
AL RE he law requ t has been c Dept. of h m 23 sho	=	DID TOBACCO U								ERTAIN			1	1 TES 2 5000
ITAL N: The law icate has b State Dept.	₹	25. WAS CASE REFERRED TO EXAMINER?				E OF DEA	171170000000			arear ar				
VISION OF VITAL ATTENDING PHYSICIAN: The Is ECTOR: After this certificate has s after death with the State De 128 is marked, or Item 2	PHYSICIAN:	1 TES 2 NO		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHE		e 5 🗆 Re	sidence	6 Other (Specify)			
YSICIA YSICIA S certif th the	ξI	27. MANNER OF DEATH		28a. DATE OF (Month, D		26b. TIM	E OF	28c. INJ	URY AT		28d. DESCRIBE HOV	INJURY OC	CURED	
NG PHYS frer this ceath with	BY		Pending Investigation	(Month, D	ay, real)	INA	IURY M		RK?] NO				
SION TENDING OR: After ther death 8 is man	ED B	0 0 0 1 1 1 1	Could not be	28e. PLACE O	F INJURY — At ho etc. (Specify)	me, ferm,	street, fac	lory, office	,		26f. LOCATION (Street	t end Numbe	r or Rural Ro	oute Number,
OTVISION OR ATTENDING DIRECTOR: After hours after death item 28 is ma		4 Homicide	determined		eter (Opocny)					l	City or Town, Ste	9)		
Pour Big	COMPLET	29e. CERTIFIER (Check only	TIFYING PHYSIC	CIAN: To the beat of	my knowledge, de	ath occum	ed at the t	ime, date	and place.	end due	to the ceuse(e) end m	enner se sie	ted	
THE HOSPITAL THE FUNERAL filed within 72 i	Š I													end manner ea stated.
HOSPI FUNE WITHIN	116	29b. SIGNATURE AND TITLE		$-\Delta$	1					NSE NUM				
TO THE HOSPI TO THE FUNER De filed within	B			10110	Junag	M)			47		100	7-16	(Month, Day, Year)
P P 2 M	임	30. NAME AND ADDRESS OF	F PERSON WHO	O COMPLETED CAUS	SE OF DEATH /ITF	M 27) (Type	Print1		-	1/(¥ ()		, ,0	17
(0)		Ravinder Ru	ıstagi					ever	lv. N	[arv]	and 2078.	5		
(6)	H	31. DATE FILED (Month, Day.	Year)		R'S SIGNATURE				,, -	,	2070.			
		JUL 20 199	15 A		rhadall									
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



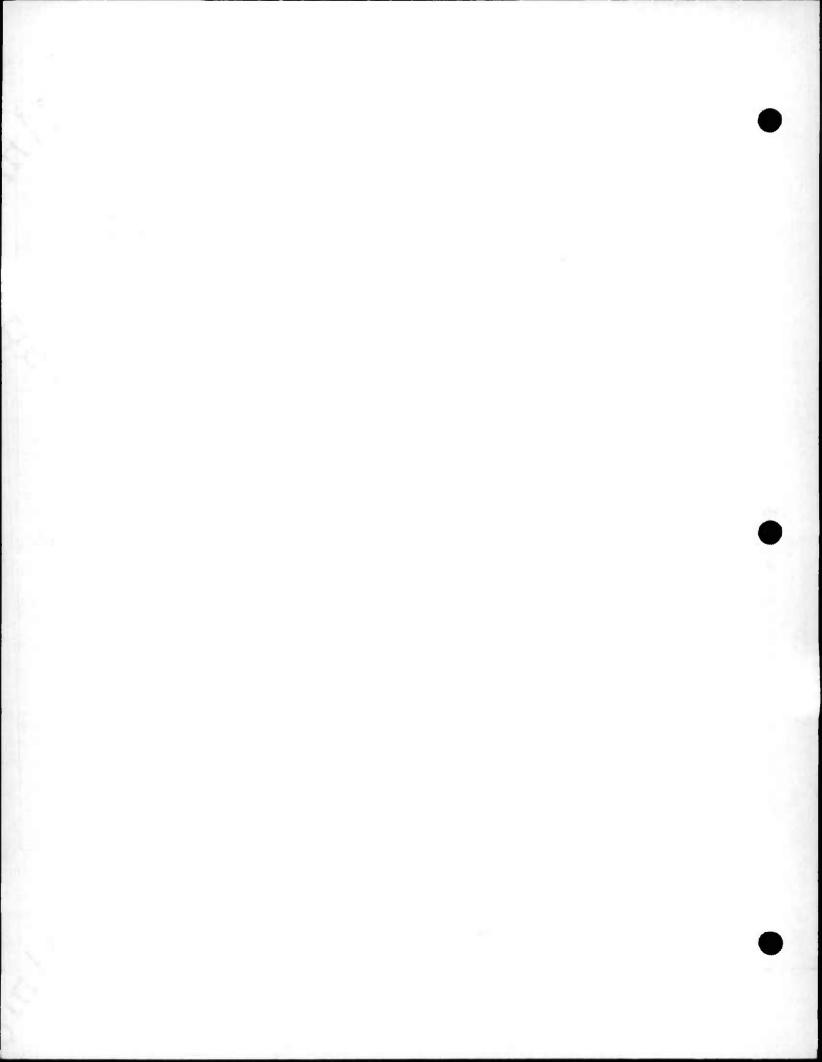
DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.

1 - STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH SEG NO.

		11201011001			- CI	-11111	ICAL	COL	DEATH		REG. NO.			
		1. DECEDENT'S NAME (First,	Middle, Last)	Tean M	errill	Dan	lr i m				2. DATE OF DEATH MONTH DA		YEAR	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (in yrs. las			R 1 YEAR	IF UNDER 24	_	7-16-95) 	a BIOTI	5:00 a M IPLACE (State or Foreign
- 1		147-20-59	40	1 🗌 M 2 👰 F	72	YRS.	MONTHS			MN.	(Month, Day, Year)		Count	(אר
		Sa. FACILITY NAME (If not in:		treet and number)	1 4	1000	9b. CIT	Y. TOWN C	PR LOCATION	OF DEA	12-16-2		NET	Jersey
	N.	794 Oak L	ane						olis					
	ECTOR	RESIDENCE OF DEC										AIII	ne A	Arundel
	DIRE	A CONTRACT	10b. COUNTY					OR LOCAT						10d. INSIDE CITY LIMITS?
	AL D	Maryland	Anne	Arund	e I	A	nnaj	poli	. S . ZIP CODE					1 Tes 2 Mo
	ERA	794 Oak L	2 7 0					101	2140			10g. CITI		WHAT COUNTRY?
	FUNE	11. MARITAL BTATUS	ane	12. WAS DECEDEN	NT EVER IN U.S. AR	MED	13.	WAS DEC			C ORIGIN? (Specify Yes	or No	U.S	
		1 Never Married 2			MAR OR DATES	10		If yes, sp	cify Cuban, &	lexican,	Puarto Rican, etc.)	UI NO	Black	E — American Indian, k, White, atc.
- 1	ВУ	3 Widowed 4 Divor	rced	5, 11, 10, 20					- 04 110	эроску.			Speci	white
	ETED	(Specify only	DENT'S EDUC highest grade	completed)	(G	CEDENT'S	work done	durina mo	ON st of working		16b. KIND OF BUS	INESS/IND	USTRY	
	PLE	Elementary/Secondary (0-	-12)	College (1-4 or 5	+)	Do NOT us								
once.	COMF	1.2 17. FATHER'S NAME (First, Mi	ridia I acti	5+	S	oci	al V	Nork	er			of N	lary	land
at 0	S	George Me									E (First, Middle, Maiden	Surname)		
B .	<u>m</u>	19a. INFORMANT'S NAME (Ty			191	b. MAILING	ADDRES	S (Street a			r Simms ute Number, City or Town	Ctate 7in	Codel	
를	2	Bruce Ran	kin			_		s #		iurar riu	ore rearribles, City or rown	r, State, Zip	(0000)	
t be		20a. METNOD OF DISPOSITION	ON	AND THE REST	20b. PLACE	AND DATE	OF DISPOS	SITION (Ne		_	DATE 20c. LOC	CATION —	City or To	wn, State
Ë		4 Donation 6 Other		OVBI Irom State	emetery, cre MD Ve	ter:	ther place) ans	Cem	eterv	7 -	+19-95 C			
all all		21. SIGNATURE OF FUNERAL	SERVICE LIC	ENSEE	1		22.	NAME AN	D ADDRESS	OF FACI	LITY	2.50		
еха		Kole	250	Sun	1		Ва	arra	nco a	nd	Sons Fu	nera	ıl H	ome
dicai		23. PART I. Enter the dis	seases, or o	omplications the	t caused the de	ath. Do r	not enter	r the mo	de of dying.	euch	as cerdiec or respir	ratory arn	est,	k MD 21146
E		IMMEDIATE CAUSE (Fine		List only one cer				0 0	20					Interval Between Onset and Deeth
t,		disease or condition resulting in death)	+	(a	(OR AS A CONSEC	m	1	t	tu /	Do	1US			
even				DUE TO	(OR AS A CONSEC	DUENCE O	F): U							
any injury, or other traumatic event, the medical examiner must be notified at	No.	Sequentially list condition		Due to	(OR AS A CONSEC									
ET .	E	if any, leading to immed cause. Enter UNDERLYIP	NG	002 10	(OH AS A CONSEC	JUENCE UI	-):							
the	트	CAUSE (Disease or injur that initiated events	y 🔰 '	DUE TO	(OR AS A CONSEC	DUENCE OF	F):							
9	CERTIFICATION	reaulting in deeth) LAST		1										
E.		PART II. Other algnificer	nt conditions	s contributing to	death but not r	equiting	in the ur	nderlylas	. course shu	o lo Di	ort i. 24a, WASAN		Lau	
E E	DICAL			- volid loading to	George But Hot I	oouting (iii tire ui	nuerrymg	ceuse give	n in Pa	PERFORI		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
	NED I										1 □ YES 2	NO		OF DEATH?
뜫	-	DID TOBACCO US	SE CONTR	PIBLITE TO CA	LISE OF DEA	TH YE	S \square	NO T	UNCER	TAINI	-			1 TES 2 NO
EZ m	SICIAN	25. WAS CASE REFERRED TO	-	TO CA		E OF DEAT			OIACER	IMIN				
or item	Sign	1 YES 2 NO	- 1	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER	R: rsing Home	Reside	nce 8	Other (Specify)			
	PHY	27. MANNER OF BEATH		28a. DATE OF (Month, D		28b. TIM		28c. INJU	JRY AT	-	8d. DESCRIBE HOW IN	JURY OCC	URED	
marked,	``		Pending nvestigation		,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		М		ES 2 N					
28 is			Could not be	28e. PLACE O building,	F INJURY — At hor etc. (Specify)	me, farm, s	dreet, fact	tory, office		7	281. LOCATION (Street at City or Town, State)	nd Number	or Rural A	loute Number,
m 2	ĒTĒ	201 0555555												
IMPORTANT: It item	COMPL										the cause(a) and mani			
ANT	8	1.5		ΩU	xamination and/or i	nvestigatio	n, in my o	opinion, de	eth occured a	t the tir	me, deta and place, and	due to the	ceuse(a) and manner ea stated.
PQ.	8	296. SIGNATURE AND TITLE	OF GERTHER	W. man	1				29c. LICENSI	NUMB	ER / /	29d. DATE	SIGNED	(Month, Day, Year)
E	ᅙ	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CALL	RE OF DEATH HATCH	1070 47-	Detect		VO	0 /	10	- /	//	8/>8
		STANLFY	WAT	ZINS	M A	Q =	STA	400	en *	+1/1	NAPIMO	2	140	/
		31. DATE FILED (Month, Day, Y		32. REGISTRA	R'S SIGNATURE			N D	1-0,1	-, 0	1,100		1 70	(
	1	JUL 9	20 199	15 Julia	Davelson	Carlel	\$							
-														

		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	RTMENT OF I	HEALTH AND	MENTA	L HYGIEN	E			
		1. DECEOENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH		3.	TIME OF DEATH	PF
		Kathryn Smit					July		1995	EAR	6:45P	М
			THATE!	yrs. lest birthday)	MONTHS DAYS	IF UNDER 24 HRS.		OF BIRTH	8.	BIRTHPL/ Country)	ACE (State or Foreign	
should		Se. FACILITY NAME (If not institution, give street		8 YRS.	Oh CITY TOWN	OR LOCATION OF O		8 190			sylvania	
1, 2, 3 sh	стов	Meridian Health (a Creek			EAIH		Anne			
Pages	DIREC	MD 106. STATE 106. COUNTY Anne A	rundel	10c, CIT	Y, TOWN OR LOCA	TION napolis			···	10 X	d. INSIDE CITY LIMITS? YES 2 NO	_
sit permit.	ERAL	106. STREET AND NUMBER 35 Milkshake Lane			10	r. ZIP CODE)3		10g. CITIZE	N OF WNA	T COUNTRY?	_
020 physician. burial-transit	FUN	11. MARITAL STATUS 1	2. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DE	CENDENT OF HISPA		i? (Specify Yee			American Indian,	_
	B	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 TYES			S 2 NO Specific		Ricen, atc.)		Black, W	white, etc.	
Se affe 21	E	15. DECEOENT'S EDUCAT (Specify only highest grade co		(Give kind of	USUAL OCCUPATION Work done during me	ON ost of working	16b	KIND OF BUS	INESS/INOUS	TRY		
N n p	LET	Elementery/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT u	se retired.)	_		_				
AND 2 the hospital detached to once.	COMPL	17, FATHER'S NAME (First, Middle, Last)	4	School	Teacher	T	ME (S)		ducat i	on		
# & & Z	Ü	Warren Kephart				18. MOTHER'S NA		WcClar	,			
AR ained hould	00	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	AODRESS (Street	and Number or Aural				rde)		
be ref	2	Mearle K. Smith		709		Circle	Sta	te Cir	cle, F	A 16		_
LIIMORE, ath. Page 6 may by meral director, page		4 □ Donation 5 □ Other (Specify)	of from State	R) HI TYPO'	ther place) Ceme terv	7/22/9	OAT		ensvil			
AL I IN death. Page funeral dir i. examiner		21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	/	22, NAME A	ND AGORESS OF FA	CIUTYJO	hn M.	Taylor	Fun	eral Hom	e
ex e e e		thalof X.	Juston		147 Du	ike of GI	ouce	ster S	t. Ann	apo I	is, MD	
ation.		23. PART i. Enter the diseases, or conshock, or heart failure. List immediate CAUSE (Final disease or condition resulting in death)	nplications that caused in tonly one cause on each	erine.	275	eda of dying, suc	0		ratory srrest	9	Approximata interval Betwee Onsat and De	
execute to burn	CATION	Sequentisity list conditions, if sny, leading to immediate	OUE TO (OR AS A C			1				-	1	
ficate physical physi	FICAT	cause. Enter UNDERLYING CAUSE (Disesse or Injury that initiated events	OUE TO (OR AS A C	ONSEQUENCE OF	F):							
7 6 8 9	CERTIFI	resulting in death) LAST										
크음을	AL (PART II. Other significant conditions of	contributing to death but	not reaulting	in the undarlyin	g cause given in	Part I.	24a. WAS AN			RE AUTOPSY FINDING	28
8 5 6 ¢	MEDIC						_	1 TYES 2		CD	MILABLE PRIOR TO MPLETION OF CAUSE DEATH?	
w requires been sign or. of Heal	¥	DID TOBACCO USE CONTRIB	SUTE TO CAUSE OF	DEATH YE	S II NO I	UNCERTAI	N [1 [YES 2 NO	
V: The law cate has be State Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL	26		H (Check only one)	- OTTOLKIZA						_
SICIAN: The certificate I the State I, or Item	YSIG	1 TYES 2 NO 1	OSPITAL: Inpatient 2 ER/Outpat	lent 3 🗆 DOA	OTHER: 4 Nursing Hom	e 5 🗆 Residence	8 🗆 Other	r (Specify)				
The with with the	ву рну	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM INJ	URY WC	URY AT PRK?	28d. DES	CRIBE HOW IN	JURY OCCUR	EO		
TTENDI TTOR: A after d	8	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify	At home, farm, (street, factory, offic	•	281. LOCA City (ATION (Street er or Town, State)	nd Number or I	Rural Route	Number,	
OR OIR	PLET	29e. CERTIFIER (Check only 1 (CERTIFYING PHYSICIA	N: To the best of my knowled	ige, death occurre	ed at the time, date	end place, and due	to the ceu	se(e) end man	ner se stated			_
TO THE HOSPITAL TO THE FUNERAL I be filed within 72 h IMPORTANT: If I	COMPL	one) 2 MEDICAL EXAMINER: (Puse(s) en	d menner ee stated,	
TO THE HOSPI TO THE FUNER De filed within	LLE III	296. SIGNATURE AND TITLE OF CHITCHEN	// /	7		29c. LICENSE NUI	MBER	T	29d. DATE SI	GNED (Mo	nih, Day, Year)	_
5 5 8 W	0 B	A-Killian	Leccu	ud		D0519	2		▶ July	/ 17	1995	
		30. NAME AND ADDRESS OF PERSON WHO CO Richard I. Hochman,		-		apolis. N	VD 21	401 (4	1⊕-268	3-75	76)	
		JUL 1 9 1995	32. REGISTRAR'S SIGNAT	Rarball								



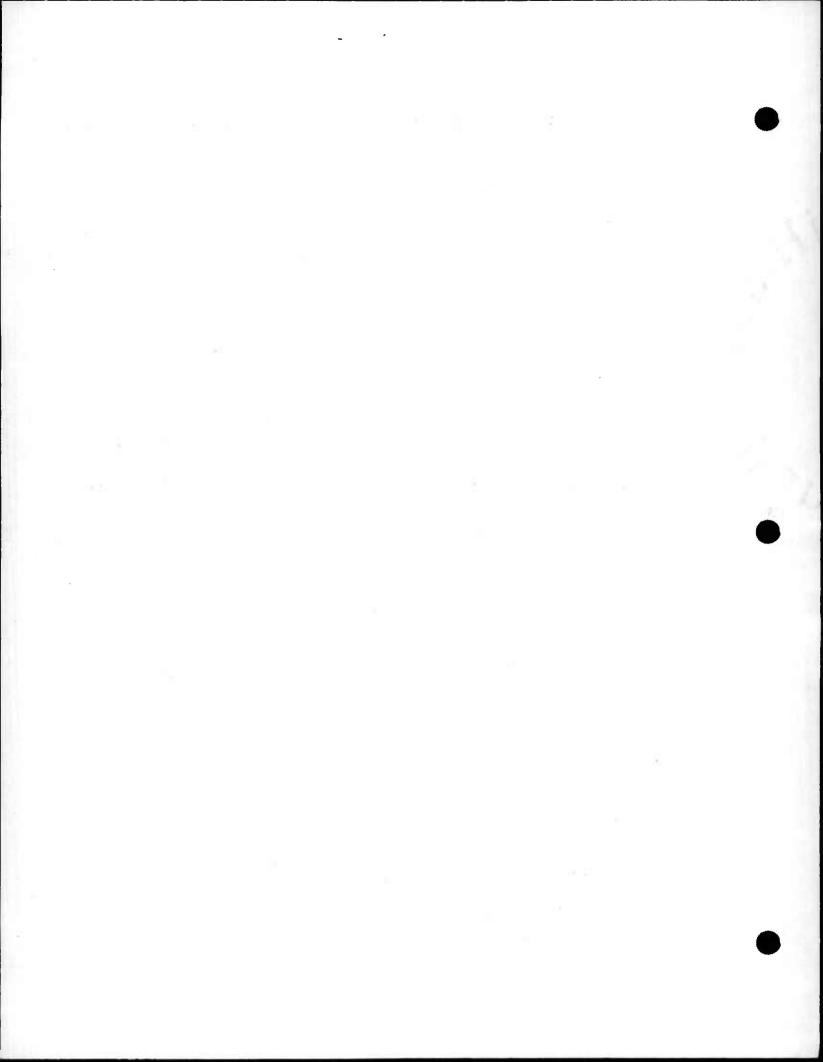
1 - STATE STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)

SARAH KATHERINE RUSSELL

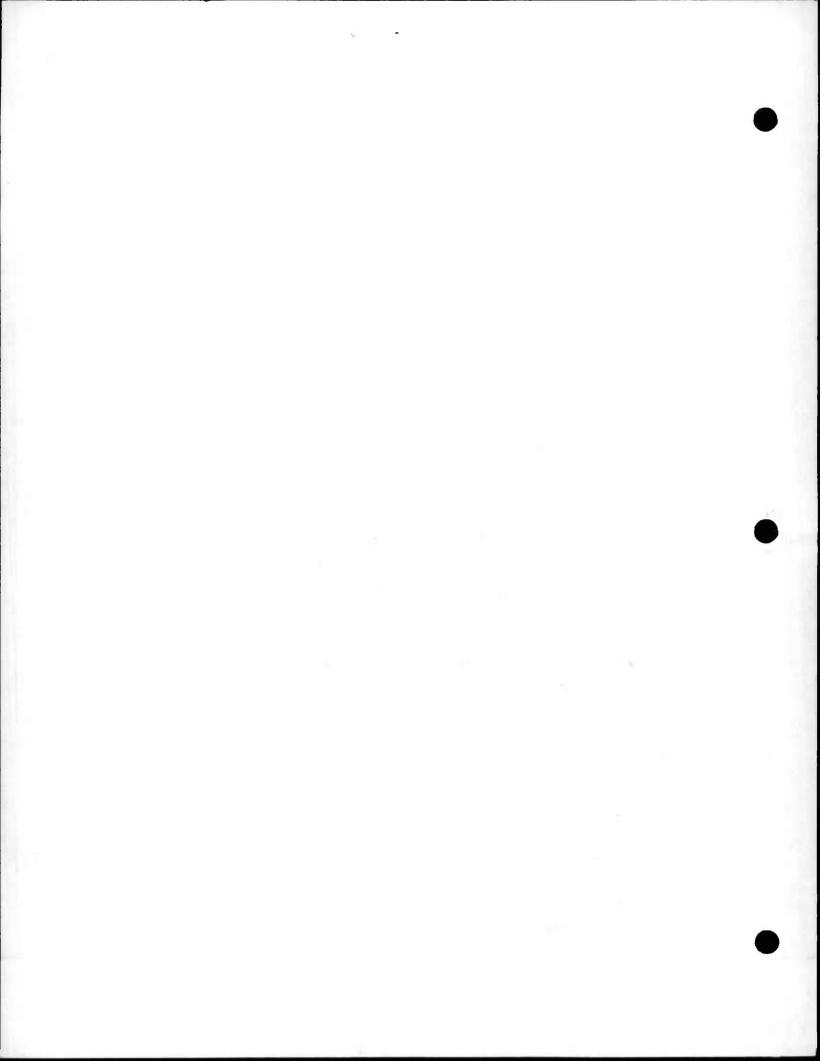
2. DATE OF DEATH MONTH DAY JUNE 27

	1 9	1. DECEDENT'S NAME (First, Middle, Last)								ATE OF DEATH			3 TIME OF DEA	TH
•		SARAH KATHE	RINE RU	SSEL	L .				וטע די	NE 27	199	95	9:35	РМ м
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AC	GE (In yrs. les	t birthday)	IF UNDER 1 Y	EAR	IF UNDER 24 HRS	7. DI	TE OF BIRTH			PLACE (State or F	
		230-18-3773	1 - M 2 - XF 7.	4	YRS.	ONTHS D	AY8	HOURS MIN.	SE	PT.5,1		Country	RGINIA	
pinous	1	9e. FACILITY NAME (If not institution, give s			- 1	Pb. CITY. TO	DWN O	OR LOCATION OF		1.3,1.	9c. COUN			
2, 3	ECTOR	CORSICA HILLS		ENTE				EVILLE	DEATH				ANNE'S	
- 2	S S	10e. STATE 10b. COUNT	,		10c. CITY,	TOWN OR I	LOCAT	TION					10d, INSIDE CIT	Y
nit. Pages	OB		N ANNE'S		CEN	ITREV	VII	LLE					LIMITS?	
it permit.	FUNERAL	10. STREET AND NUMBER		_			101.	. ZIP CODE			340		HAT COUNTRY?	
physician. burial-transit	焸	105 CHESTERFI					L,	21617				JSA		
g physician e burial-tra	E	1 Never Married 2 Merried	12. WAS OECEDENT EVE FORCES? 1 YI	S 2 X	MED IO	13. WAS	S DECI	ENDENT OF HISI ecify Cuben, Mex	PANIC ORI	GIN? (Specify Yes	or No-	14. RACE Black	- American Ind , White, atc.	len,
or attending p) BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR OF	DATES		10	YES	2X NO Spe	ic#y:			Specif	WHITE	
r afte	TED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(G	CEDENT'S US	rk done duri				16b. KIND OF BUS				
	COMPLET	Elementary/Secondery (0-12)	College (1-4 or 5+)	life.	Do NOT use i	retired.)				CROWNS	SVILI	LE S	STATE	
the hospital detached for	MP	12		1	NURSE	S A	[DE	E		HOSPIT	TAL			
the hose detach	8	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S	NAME (Fir	st, Middle, Melden	Surname)			
d be	ш	DAVID CLARENC	E KELLER					JUAN	ITA	BALL				
retained 5 should	TO B	19e. INFORMANT'S NAME (Type/Print)		198	. MAILING A	DDRESS (S	treet ar	nd Number or Rui	al Route N	umber, City or Town	n, State, Zip	Code)		
y be	-	DAVID M. RUSS			LO3 C					E., CEN				216
e 6 m rector.		Buriel 2 Cremation 3 Rem-						EMETER		-30 CEN	CATION — C		E, MD	
rai d		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. NAI	ME AN	D ADDRESS OF	FACILITY					
9 7 9		JOHN R A	ERCERON) (523	20) () SMD	S. HA	NEKA RRTS	AL HOME SON ST.	s, P.	. А. АЅТС	UM MD	
ic of E		23. PART I. Enter the diseases, pr	omplications that caus	sed tha de	ath. Do not	enter the	e mod	da of dying, s	uch ss c	ardiac pr reaple	ratory erre	at.	Approxim	nete
		shock, or haert failure. IMMEDIATE CAUSE (Final	List only one cause or	each line	v								Interval E	etween
y filled ation, or the m		disease or condition	Rosa	-1.	Fre		•	304	0	1200			Onset an	d Death
completely ial. cremat,		resulting in death)	DUE TO (OR A	S A CONSEC	DUENCE OF:	· will	_	0 10		011)	-		1041	
ecuted ind com burial.	_	_	,,,,,,										j	
e be executivition to buristical traumatic	CATION	Sequantielly list conditions, if any, leading to immediate	DUE TO (OR AS	S A CONSEC	UENCE OF):								-	
	AT	cause, Entar UNDERLYING											į	
ertificat ing phy giene p	ERTIFIC	CAUSE (Disease or Injury that initiated events	DUE TO (OR A	S A CONSEC	DUENCE OF):								+	
. 5 5 E	H	resulting in deeth) LAST	4:											
	0													
= 20 =	DICAL	PART II. Other significant condition							In Part i.	24a. WAS AN		24b.	WERE AUTOPSY F	
8 5 6 5 (음	Diabetes,	Bullou-	ssu	in A	rec	كدا	2		1 TYES 2			COMPLETION OF DF DEATH?	
requires en sign of Healt	ME												1 YES 2	NO
		DID TOBACCO USE CONTI	RIBUTE TO CAUSE	OF DEA	TH YES	□ NC		UNCERTA	MN 🗆			1		
rSICIAN: The law riscontificate has been the State Dept. (d. or item 23 s.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			E OF DEATH									
NN: T ficat Stat	SIC	EXAMINER? 1 Tes 2 Setto	HOSPITAL: 1 Inpatient 2 ER/O	utpatient 3	□ DOA	THER:	Home	e 5 🗆 Residenc		ther (Specify)				
SICIAL certif	Η	27. MANNER OF DEATH	28e. DATE OF INJUR	Υ	28b. TIME C	OF 28	c. INJL	URY AT	7	DESCRIBE HOW IN	LIURY OCCI	IBED		
子 章 x 5		12 Netural 5 Pending	(Month, Day, Year)	INJUR	IY .	WOF	RK? (ES 2 NO						
NDING F t: After r death	ВУ	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJU	RY — At hor	me, farm, stre				281 1	OCATION (Street a	nd Number o	e Bural B	nesta Mesmbar	
DR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has thours after death with the State Deptilem 28 is marked, or item 23	ED	4 Homicide determined	building, etc. (S	pecify)	,,	, maio , j	Ollico		201.0	ity or Town, State)	na Nomber o	r nurar no	oute Number,	- 1
DR AI DIREC hours	9	29e. CERTIFIER					-							
로 로 전 보	MP	(Check only	CIAN: To the best of my kn											
THE HOSPITAL THE FUNERAL filed within 72 P	COMPLET	Z MEDICAL EXAMINE	R: On the besis of examinar	tion end/or i	nvestigation,	In my opini	ion, de	eath occured at t	he time, d	ate end place, end	due to the	ceuse(s)	end manner es i	stated.
TO THE HOSPI TO THE FUNER be filed within	BE (296. SIGNATURE OF TITLE OF CERTIFIER					\neg	29c, LICENSE N	UMBER		29d. DATE	SIGNED	(Month, Day, Year)	
E S S S S S S S S S S S S S S S S S S S		/1 U/MW	Com					033	203	6	> (6/2	8155	.
	2	30. NAME AND ADDRESS OF BERSON WH	COMPLETED CAUSE OF				,	7 1/2				-0		\neg
		Gay Jor	one 21	90	P.D.	م در	to	Drive	2 (hesten	M	0	2/6/5	; I
	ŀ	31. DATE FILED (Month, Day, Year)	BEGISTRAR'S' SH	GNATUGE	latt.			77.		4,5				
		JUN 2 9 1995	Jacon Delica	ev smill	-									ĺ



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	OB	OIRE	DOUTS	
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending p	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the b	2	
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		FOR		STATE OF I	MARYI AI	ND /	DEPAR	TMENT	UE P	IEAIT	LI AND I	MENTA	LUVCIEN	-	J 6	20200	
		1 - STATE REGISTRAR		OINIE OI I	VIAITIEN		RTIF					MENTA	REG. NO.	-			
ĺ		1. OECEDENT'S NAME (Flish Evelyn	, Middle, Last)	Robins								MONT		4 10	YEAR	3. TIME OF DEATH	
		4. SOCIAL SECURITY NUME	ER	5. SEX	8. AGE (In	yrs. les	birthday)	# UNDER	1 YEAR	IF UND	DER 24 HRS.	Ju.	Ly 17	19	95	7:35 A N	
		213-22-466	2	1 □ M 2 √ F		84		MONTHS	DAYS	HOUR	B MIN.	(Mon	th, Day, Year)	011	Count	(Y)	
		9e. FACILITY NAME (If not in						9b. CITY,	TOWN	OR LOCA	TION OF DE	EATH	1 8, 1	9c. COU	I Mar	yland EATH	
	[일	Meridian		Pines					Eas	to	n			Ta	lbot	t	
	DIRECTOR	10a. STATE	10b. COUNT	Y			10c. CIT	Y, TOWN O	R LOCAT	ION						10d, INSIDE CITY	
		Maryland	Ta1	bot			E.	astor	ı							LIMITS?	
	FUNERAL	10a. STREET AND NUMBER								ZIP CO				10g. CIT	IZEN OF	WHAT COUNTRY?	
	빙	621 Dove	r Road	12. WAS DECEDEN	IT EVER IN I	IS ADI	WED.	49.1		216			N? (Specify Yee		SA		
		1 Never Married 2		FORCES? 1	YES	2 X N	0	1 1	yes, sp	ecify Cu	ben, Mexical O Specify	n, Puerto	N? (Specify Yee Rican, etc.)	or No—	Black, White, etc.		
	98	3 X Widowed 4 Divo		17						- 24 "	О ороспу				Spec	Black	
	TE	15, DEC (Specify only Elementary/Secondary (0	EOENT'S EOU	completed)		(Gh	CEDENT'S ve kind of v Do NOT us	vork done o	CUPATIO	ON slofwor	rking	161	. KIND OF BUS	INESS/IN	DUSTRY		
	COMPLETED	5th	-12)	College (1-4 or 5	+)		mest						Domes	stic			
once.	Š	17. FATHER'S NAME (First, M	iddle, Last)							18. MC	THER'S NA	ME (First,	Middle, Malden				
	BE	Harvey Wi				_					Sarah						
notiffi	၉	19a. INFORMANT'S NAME () Rev. Harv		100									ber, City or Town				
t be		20a. METHOD OF DISPOSIT	ON		20b, Pi		ND DATE				ambri	Lage	Md. 2	-	City or To	wn State	
must		1 X Burief 2 Cremetic 4 Donation 5 Other	n 3 🗆 Rem (Specify)	oval from State	cemete	Cha	nalory or of	her place) Chur	ch (Ceme	tery	720	0/95 E		on, M		
examiner		21. SIGNATURE OF FUNERAL	L SERVICE LIC	ENSEE					IAME AN	ID ADDE	RESS OF FAC	CILITY	neral				
exa.					>								Easton				
u, cremation, or removal.		23. PART i. Enter the disease, or complications that coused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, abock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):															
Hygiene prior to burial, or other traumatic e	CERTIFICATION	disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death															
of Health and Me hows any inju	MEDICAL	PART II. Other eignifice	hem	iparesis ident	due	Ko	les	y ce	rebi	ords	given in in cular	_	24a. WAS AN A PERFORI 1 YES 2	WED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
State Dept	PHYSICIAN:	25. WAS CASE REFERRED TO					OF DEAT			- 014	CERTAIL	1 1					
or Ite	2	1 YES 2 NO		HOSPITAL: 1 Inputient 2	ER/Outpation	ent 3	□ DOA	OTHER		5 🗆	Residence	6 🗆 Othe	er (Specify)				
marked,		27. MANNER OF DEATH	Pendina	28e. DATE OF (Month, D			28b. TIME	OF JRY	28c. INJI WO			28d. DE	SCRIBE HOW IN	JURY OC	CURED		
death mar	0	2 Accident	nvextigation	28e. PLACE O	F INJURY	At hon	ne farm e	M real facto		ES 2	□ NO	281 1.00	ATION (Common				
28 is	2		Could not be letermined	building,	etc. (Specify))	,	ireei, iucio	ry, onic			City	ATION (Street as or Town, State)	nd Number	Or Murai H	loute Number,	
2 = 3	COMPLE			CIAN: To the beat of) and manner ee stated.	
IMPORT		The	296. SIGNATURE AND THE OF CONTINER								29c. LICENSE NUMBER DZS933 29d. DATE SIGNED (Month, Day, Year) 7.7.95					(Month, Day, Year)	
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typa, Print) (YOW Ley, MD Faston, M) 21601															
		31. DATE FILED (Marin, Day.	71995	JE REGISTRA	R'S SIGNATI	land	all										



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the state of the s	er th	er death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
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				(*)						9	5 2	3260		
	FOR 1 - STATE REGISTRAR	STATE OF N	MARYLAND C	/ DEPAR	TMEN	T OF H	EALTH DEAT	AND I	MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH		:	3. TIME OF DEATH		
	Mary Myrtle	2	ROEMER						July 20	AY 1	YEAR 1995	11:35 A M		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	est birthday)		ER 1 YEAR	IF UNDER :		7. DATE OF BIRTH	<u> </u>	6. BIRTHPI	LACE (State or Foreign		
	217-38-6180	1 🗆 M 2 💢 F	95	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) April 20.	1000	Moran			
	9a. FACILITY NAME (If not institution, give :	street and number)			9b. CIT	Y, TOWN	OR LOCATIO	N OF DE	ATH	9c. COU	NTY OF DEA	у тапа		
5 Franklin Square Hospital Rossville										Baltimore				
DIRECTOR	RESIDENCE OF DECEDENT					1100	01111			Dar	Imore	2		
2	10a. STATE 10b. COUNT			10c. CIT	Y, TOWN	OR LOCAT					1	IOd. INSIDE CITY LIMITS?		
		ltimore				Bal	timor	e Co	ounty		1	YES 2XX NO		
FUNERAL	10e. STREET AND NUMBER					101	. ZIP CODE			10g. CIT	IZEN OF WH	IAT COUNTRY?		
ij	335 Homberg Aven	ue					2122	21-3	174		USA			
5	11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A	RMED	13	. WAS DEC	ENDENT OF	HISPAN	IC ORIGIN? (Specify Ye	or No-	14. RACE -	- American Indian, White, atc.		
BY I	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES	jato		1 TYES	2 NO	Specify	n, Puarto Rican, etc.)		Specify:			
		<u> </u>									V	White		
COMPLETED	15. DECEOENT'S EOU (Specify only highest grade	CATION completed)	(Give kind of	work done	durina mo	ON st of working	,	16b, KIND OF BU	SINESS/INC	DUSTRY			
<u>"</u>	Elementary/Secondary (0-12)	College (1-4 or 5 +)	fe. Do NOT u					l					
M	8th grade	N/A		House	wife				Homema					
	17. FATHER'S NAME (First, Middle, Last)								ME (First, Middle, Meiden	,				
BE	George Howe								mina Simon					
2	19a. INFORMANT'S NAME (Type/Print)		1	9b. MAILING	AOORES	SS (Street e	nd Number o	or Rural F	loute Number, City or Tow	n, State, Zip	Code)	0374		
	Louis George Roe	ner		335 I	dmor	erg	Avenu	ie R	altimore,	md. 2	51551-	-31/4		
	20e, METHOD OF DISPOSITION 1 A Burlet 2 Cremation 3 Ram	oval from State	20b. PLACE	ANDDATE	OF DISPO	SITION (No	me of		1	CATION -	City or Town	n, State		
	4 Donatton 5 Other (Specify)		Zior	Chu	rch	Ceme	tery	7.	-24 - 95 Ba	ltimo	ore, N	Md.		
	21. SIGNATURE OF FUNERAL SERVICE LIC	_			22	. NAME A	O ADDRES	S OF FAC	ILITY 7	401 5	Belai	n Dd		
	Heather Les	sohn			L	assa	hn Fυ	nera	al Home			. 21236		
	23. PART I. Enter the diseases or o	complications that	caused the d	laath. Do r	ot anta	r the mo	de of dvin	a such	as cardiac or reco	Inches on	, nu			
	anock, or naart langre.	List only one caus	se on each iin	la.				.g,	, as salated of loop	nasory an	out,	Approximate Interval Between		
	iMMEDIATE CAUSE (Final disease or condition					_						Onaet and Death		
	resulting in death)	a. Cereb	COVASCU	Lar a	cci	dent						8 days		
	_				•	1.2 .								
ERTIFICATION	Sequantially list conditions,		icular			ala						11 days		
AT	if any, leading to immediata cause. Enter UNDERLYING				,									
윤	CAUSE (Disease or injury that initiated events	DUE TO	OR AS A CONSE	EQUENCE OF):									
E	resulting in death) LAST													
빙		J												
A	PART II. Other significant condition	s contributing to	death but not	resulting	n tha u	ridarlying	cause gi	ven in l			24b. W	ERE AUTOPSY FINDINGS		
8		,	`						PERFOR		C	WAILABLE PRIOR TO OMPLETION OF CAUSE		
¥.	{									20		F GEATH?		
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTI	RIBUTE TO CAL	USE OF DEA	ATH YE	s 🗆	NO K	UNCE	RTAIN				0 .40 1 0		
Ĭ.	25. WAS CASE REFERRED TO MEDICAL			CE OF OEAT		_								
Sic	EXAMINER? 1 YES 2 X NO	HOSPITAL:	ER/Outpatient	3 DOA	OTHE 4 Nu		s 5 □ Beel	Idence (5 Other (Specify)					
<u> </u>	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIM	E OF	28c. INJ	JRY AT		26d. DESCRIBE HOW I	NJURY OCC	CURED			
ВУР	1 Netural 5 Pending trivestigation	(Month, De	ry, Year)	INJ	URY		RK?	NO						
	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF	INJURY — At h	ome, farm, s	treet, fec	tory, office		-	28f. LOCATION (Street a	nd Number	or Rural Rou	te Number		
COMPLETED	4 Homicide determined	building, a	etc. (Specify)	,		ŧ			City or Town, State)					
W	29a. CERTIFIER	CIANI To the	- bar to the	Na andra						-				
MP	(Check only one) 290. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC ONE)	R: On the heels of	my Knowledge, de	eath occurre	a st the	time, data	and place, a	and due t	to the cause(a) and mar	mer aa atate	ed.			
8				vestigati0	o, or my	opinion, de	HITT OCCUPE	at the t	ime, date and place, an	due to the	e cause(a) a	nd manner as stated.		
H	296. SIGNATURE AND TITLE OF CERTIFIER	2011					29c. LICEN	SE NUM	BER	29d. DATE	7/2	lonth, Day, Year)		
0	runar 1.	O COMPLETED CAUSE	2		70		D473	<u>35</u> 0			1/20	0/55.		

9000 Franklin Square Drive Baltimore, MD

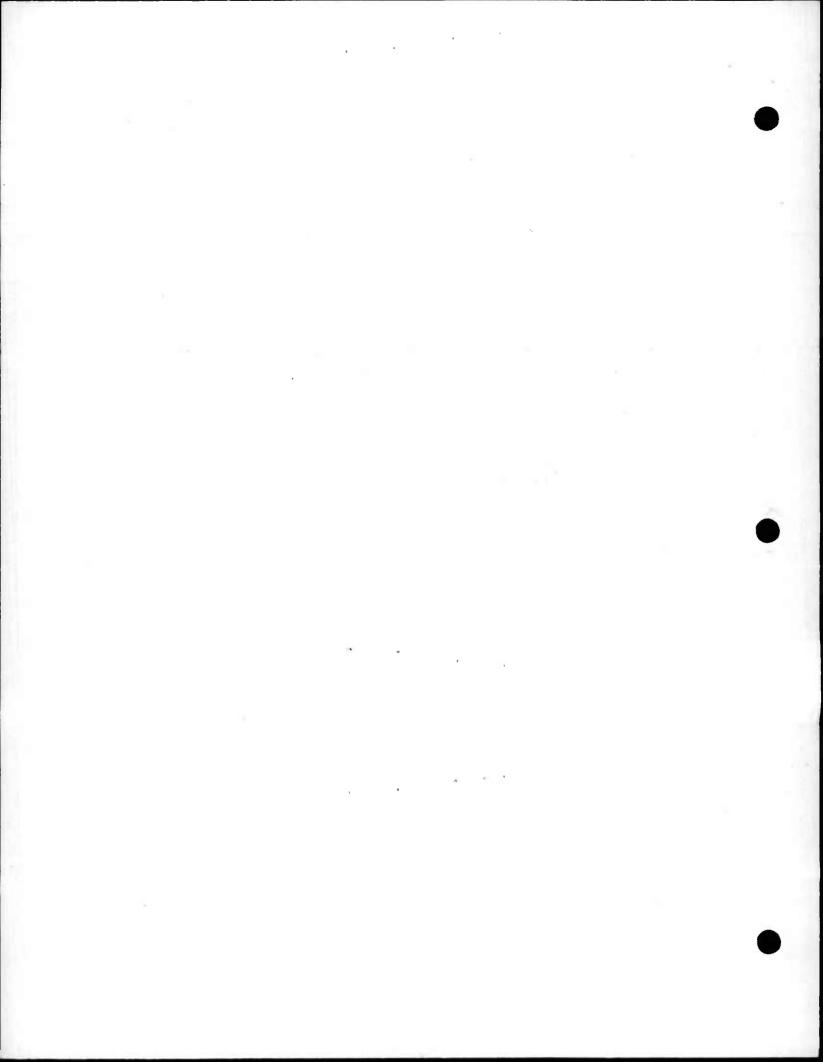
30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

M.D.

Kumar Dalla,
31. DATE FILEO (Month, Doy, Year)
JUL 2 & 1995

21237



BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	ed in by the funeral director, page 5 should be detached for use as the burial-transit
DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020	P!TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ERAL OIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buffal-transit on 70 hours after health with the State Dear of Health and Mandal Hunlane prior in hunlal cremation or removed.

	REGISTRAR	P. 110				OF [O				
	1. DECEDENT'S NAME (First, Middle,	***						2. DAT	E OF OEATH	DAY	YEAR	3. TIME OF DEATH		
	Carol Ann							Ju	1y 1	8	1995	9:30		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.		IF UNDER 1 Y	_	IF UNDER 24 HRS	10.4	E OF BIRTH		6. BIRTH	IPLACE (State or Foreign)		
	388-42-3799	1 🗆 M 2 😾 F	50	YRS.			moons min	Ja	n. 8,	1945	Wisc	onsin		
_	9a. FACILITY NAME (If not institution,	give street and number)			9b. CITY, TO	OWN OR	LOCATION OF	DEATH		9c. COI	UNTY OF D	EATH		
Ö	33 Main Stre	et			New	Mai	rket			F	reder	ick		
DIRECTOR		OUNTY		10c CI7	Y, TOWN OR L	LOCATIO	NA.							
H				100. 011								10d. INSIDE CITY LIMITS?		
	Maryland 100. STREET AND NUMBER	<u>Frederick</u>			New M	-						1 X YES 2 NO		
FUNERAL	A COUNTY OF THE PARTY OF THE PA						ZIP CODE			10g. CI	TIZEN OF Y	WHAT COUNTRY?		
W	33 Main Str						21774				USA			
	1 Never Married 2 Married	FORCES?	TENT EVER IN U.S.		13. WAS	S DECEN	NDENT OF HIS	PANIC ORIG	IN? (Specify Y	ea or No	14. RACE Black	- American Indian, k, Whita, atc.		
BY	3 Widowed 4 Divorced	IF YES, GIVE	WAR OR DATES	11			XNO Spe		Charles I		Speci	ty:		
	15. DECEDENT'S	S EDUCATION	100	DECEDENTIO	USUAL OCCU	10471011		Lon				white		
E	(Specify only highest	grade completed)		(Give kind of life. Do NOT u	work done durin	ing most	of working	16	b. KIND OF B	USINESS/IN	DUSTRY			
7	Elementary/Secondary (0-12)	College (1-4 or 5	í I .		70.000.7				-	3				
COMPLETED	17, FATHER'S NAME (First, Middle, La.		10	wner		_	14			lry S	Store			
	Comments of the Comments of th						18. MOTHER'S	NAME (First,	Middle, Maide	n Surname)				
BE	Robert Edward G			Pre serience			Jeanet							
2		,					Number or Rui							
	Gene Rooney						t, New							
	20a. METHOD OF DISPOSITION 1 General 2 Cremation 3 General Cremation 3 General Cremation 3 General Cremation 3 General Cremation 3 General Crematical Crem	Removal from State	cemetery.	Cremetory or a	OF DISPOSITIO	ON (Name	e of	7.61	100	OCATION —				
	4 Donation 5 Other (Specify)		_ Hag	erstov	m Crei			199	5 Has	erst	own,	MD		
	25. NAME AND ADDRESS OF FACILITY													
	Stauffer Funeral HOmes, P.A. P.O. Box 1819, Frederick, MD 21702													
	Munu	M. A	30101	' A	Sta	auf	fer Fu	neral				702		
	23. PART I. Enter the diseases	o, or complications th	at ceused fie	deeth Dn	Sta P.	aufi	fer Fun Box 18	neral	rederi	ck. I	MD 21			
		lure. List only one ca	nat ceused the nuce on each ii	deeth. Do s ne.	Sta P. (auf 0.]	fer Fur Box 18 of dying, s	neral 19, F uch as can	rederi	ck. I	MD 21	Approximate Interval Betw		
	IMMEDIATE CAUSE (Final disease or condition	lure. List only one ca	nat ceused the nuce on each ii	deeth. Do s ne.	Sta P. (auf 0.]	fer Fur Box 18 of dying, s	neral 19, F uch as can	rederi	ck. I	MD 21	Approximate		
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ion	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	lure. List only one ca	at ceused fie	deeth. Do s ne.	Sta P. (auf 0.]	fer Fur Box 18 of dying, s	neral 19, F uch as can	rederi	ck. I	MD 21	Approximate Interval Betw		
CATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING	lure. List only one ca	nat ceused the nuce on each ii	deeth. Do s ne.	Sta P. (auf 0.]	fer Fur Box 18 of dying, s	neral 19, F uch as can	rederi	ck. I	MD 21	Approximate Interval Betw		
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ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M. John Kennely Oncology 13d Johns Hyplein Haspital 600 NWU/4 St

32. REGISTRAR'S SIGNATURE

M. John
31. DATE FILED (Month, Day, Year)

JUL 1 9 1995

7-18-75

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after death. Page 6 may be retained by the hospital or attending physician. by the funeral director, page 5 should be detached for use as the burial-transit BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760, executed with HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be attending this c After DIRECTOR: Af hours after de item 28 is r

Pages 1, 2, 3 should permit. te notified be Must examiner n by the fremoval. medicai 6 completely filled rial, cremation, c event, the and com traumatic ung physician a 9 Health and Mental H Injury, shows any been it. of Dept. s certificate has b marked,

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FUNERAL E within 72 h TO THE HOSPITA
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IMPORTANT: II

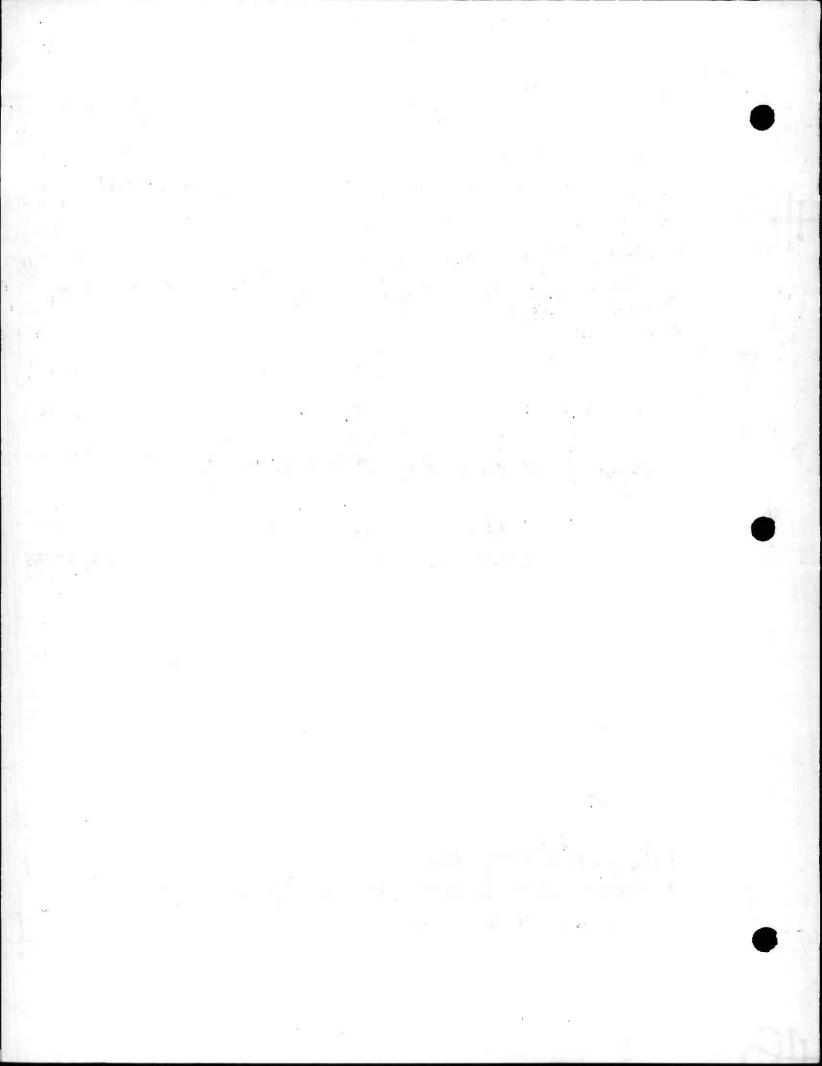
95 23262 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF GEATH 3. TIME OF DEATH 1995 JULY LYDIA Ε. ROCK 10:30 Α 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 5. SEX 6. AGE (in yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 F 385-22-1753 YRS. MARCH 3,1901 MICHIGAN 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF DEATH DIRECTOR 17508 PARK MILL DRIVE DERWOOD MONTGOMERY RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY MARYLAND MONTGOMERY DERWOOD 1 - YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 17508 PARK MILL DRIVE 20855 UNITED STATES 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yaa or NoIf yea, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married Specify: WHITE BY 3 Widowed 4 Divorced COMPLETED 15. DECEOENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY ive kind of work done . Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame, FREDERICK FANSLOW FREDRICKA (UNKNOWN) BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DONALD B. ROCK 17508 PARK MILL DRIVE DERWOOD, MARYLAND 20855 28a, METHOO OF DISPOSITION

125 Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata NORBECK MEMORTAL PARK 4 Donation 5 Other (Specify) 7/26/95 OLNEY, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
MURIEL H. BARBER FUNERAL HOME 20882 Duri .O. BOX 5038 LAYTONSVILLE, maryland 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition_ reaulting in death) TERIOSCIEROSIS CERTIFICATION

intarvai Batween **Onset and Death** Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED DO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER 1 TES 2 NO 1 | Inpetiant 2 | ER/Outpetlant 3 | DOA ng Home 5 (Raaldenca 8 - Other (Specify) 27. MANNER OF OEATH 28a, DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation 1 YES 2 NO 2 Accident 3 Sulcida 28a. PLACE OF INJURY — Al home, farm, street, factory, oHica building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29a CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAM on and/or investigation, in my opinion, dasth occured at the time, data and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year) JULY 24, 1995 1445 WHO COMPLETED CHUSE OF OEATH (ITEM 27) (Type, Print) DR. THOMAS E. DOOLEY 17904 GEORGIA AVENUE OLNEY, MARYLAND 20832

31. REGISTRAR'S SIGNADIRE



1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO

		112010111011				OLIT	TH TOAT	- 01	DLA	111	_	REG. NO.				
		1. DECEDENT'S NAME (First,	, Middle, Last)	ALIC	E	R	ICHARD	SON			2. DATE OF DEATH DAY OF PEAF OF 19 95		YEAR	3. TIME OF DEATH	Ам	
		4. SOCIAL SECURITY NUMBER	IER	5. SEX	6. AGE (In	yrs. last birt	hday) IF UNDER	1 YEAR	IF UNDER	1 24 HRS.	7. DATE	OF BIRTN		8. BIRTHP	LACE (State or For	
P		216-54-99		1 🗌 M 2 💢 F	100) v	/RS. MONTHS	DAYS	HOURS	MIN.	APR	9 1895	5	MARY	LAND	
3 should	œ	90. FACILITY NAME (If not in			TATTO				OR LOCATI	ON OF DE	EATN		9c. COUN			
1, 2, 3	20	BERLIN NURS		KEHABILI	TATTU	IN CEN	A' BE	RLI	N				WORC	ESTE	R	
Pages	REC	10a. STATE	10b. COUNTY			10	c. CITY, TOWN	R LOCA	ATION						10d. INSIDE CITY	
خ	<u> </u>	MARYLAND	WORC	ESTER			BERL	IN	_						LIMITS?	NO
t permit.	FUNERAL	10s. STREET AND NUMBER						10	or. ZIP COD	_			10g. CITIZ	EN OF WI	AT COUNTRY?	
DZO physician. burial-transit	밀	PO BOX 799							21813					U.S.		
DZO Ohysic Ourial-		1 Never Married 2	Married	12. WAS DECEDEN	YES	2 XNO	1	If yes, s	pecify Cube	in, Mexica	en, Puerlo	IN? (Specify Yes Rican, etc.)	or No-	Black,	 American India: White, etc. 	n,
F 2 2	B	3 🔀 Widowed 4 🗌 Divo	rced	IF YES, GIVE Y	NAH OH DATI	ES		1 YE	S 2 💢 NO	Specif	specify: WHITE					
attenc	9	15. DEC (Specify only	EDENT'S EDU	CATION completed)	1	18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)						b. KIND OF BUS	INESS/INDU			
ğ gg Y	틸	Elementary/Secondary (0	-12)	College (1-4 or 5	+)	life. Do i	NOT use retired.)				OLOTUTUO OL TANTONO OLOTU					
AND he hospit detached once.	COMPL	17. FATHER'S NAME (First, M.	iddle (est)			SEAM	<u>ISTRESS</u>							ANTN	G & RFP	ATR
be deta		CHARLES A.									, , , , ,	Middle, Malden	Sumame)			
retained to 5 should notified	BE	19e. INFORMANT'S NAME (7)			-	19b. MA	AILING ADDRES	S (Street				YOUNG	State Zin (Corde)		
2 2 2	임	SUZANNE LO	BDELL				5 LINDA						2182			
. Page 6 may be ral director, page		20e. METNOD OF DISPOSITI	n 3 🗆 Remo	oval from State			DATE OF DISPOS TO OTHER DISCO				DA		CATION — C			
ALLIMOR leath. Page 6 m funeral director, xaminer musi		4 □ Donation 5 □ Other 21. SIGNATURE OF JUNERAL		PRIEE /	_ Bt	EECHW			-	SS OF FA		22 PRI	<u>VCESS</u>	ANN	E, MD.	_
death. Pag tuneral di i, examiner		21. SIGNATURE OF UNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HINMAN FUNERAL HOME														
		23. PART /. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate														
filled ir on, or he me		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ATHEROSCIETION CORRESPONDED TO SEASE													twean	
9 5 5 6	_	DUE TO (OR AS A CONSEQUENCE OF):														
e be executed by the strian and confident to buning traumatic	RTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):														
ie phy	FIC	Cause, Enter UNDERLYING CAUSE (Disease or Injury														
eath certification attending that Hygier	HTI	that initiated evanta DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST														
C 6 6 0	CEI	PART II. Other algnifica	nt condition	o goodalbudlas da	death has		M 1 - M								+	
- 55 L	MEDICAL	PART II. Othan arginica	Condition	a contributing to	oaam put	t not resul	iting in the ur	derlyir	ng cause (given in	Part I.	24s. WAS AN PERFOR	MED?	1	VERE AUTOPSY FIN WAILABLE PRIOR TO COMPLETION DF CA	0
tuires that signed Health a	EDI											1 - YES 2	A NO		OF DEATN?	
St o ee de	-	-			_									'	YES 2 X N	0
AL he law t has t e Dept	IAN:	25. WAS CASE REFERRED TO	D MEDICAL					26. P	LACE OF D	EATN (Ch	eck only o	ine)				
SICIAN: The certificate h the State h	SICI	1 YES 2 NO		HOSPITAL: 1 Inpatient 2	☐ ER/Outpati	lant 3 🗆 D	OFHEI		me 5 🗆 Re							
호 돌 돌 호	у РНУ		Pending Investigation	28e. DATE OF (Month, D		28	b. TIME OF INJURY	28c. 1N W	JURY AT ORK? YES 2			SCRIBE HOW IN	JURY OCCL	IRED		
DR ATTENDING F DIRECTOR: After thours after death item 28 is mar	ETED BY	3 Suicide 8	Could not be determined	28e. PLACE O	F INJURY — etc. (Specify	At home, (ferm, street, fec	ory, offi	ce		28f. LOC	CATION (Street a or Town, State)	nd Number o	r Rural Roi	ute Number,	
DR AT DIREC hours	Ē	29e. CERTIFIER	TEVINO BUYOU	01411 To 11 4 4 4		rii Turk										
E BE	COMPL			CIAN: To the best of a											end menner es ste	rted.
THE HOSPI THE FUNE filed within	ш	296 SIGNATURE OND TITLE	OF CERTIFIEF	0 - 0 0)	>	SAAT	_	29c. LICE	ENSE NUI	MBER	1	294. DATE	SIGNATO (I	Month/Day, Mear)	
5 5 3 8	TO B	30. NAME AND ADDRESS OF	PERSON WIN	O COMPLETED CALL	SE OF DEAT	N /ITEM 27	(Time Dilet)	_	D4	6257			• 7	1/19	195	
54		EDWIN CA					PINE R	DAD	WIL	LARD	S	MD 218	74 /	- (
		31. DATE FILED (Month, Day,	_ 1	REGISTR	AR" SIGNAT	ME					-			-		
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31. DATE FILED (Month, Dey, Year)

JUL 2 0 1995

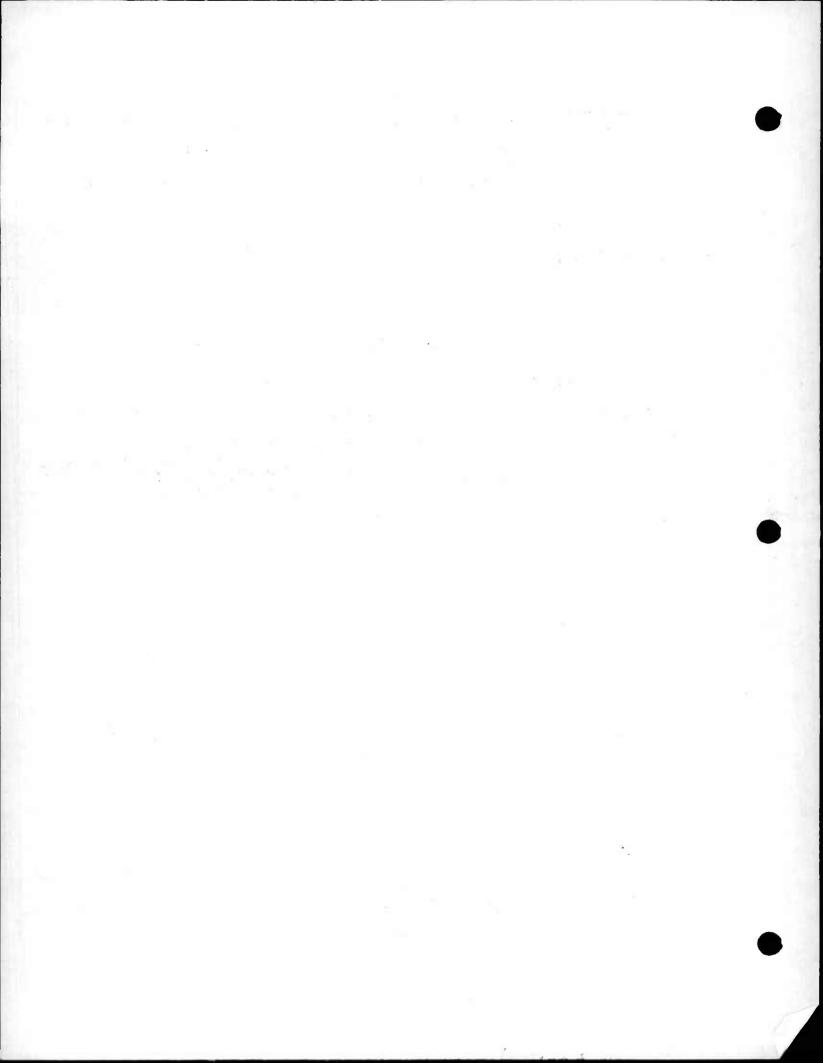
32. REGISTRAR'S SIGNATURE

		1 - FOR STATE REGISTRAR		STATE OF A	MARYL	AND /	DEPAR	TMENT	OF I	HEALTH	AND N	MENTA	L HYGIEN	E		
		1. DECEDENT'S NAME (Firs	t, Middle, Last)								T		E OF DEATH			3. TIME OF DEATH
		LAWRE	NCE A	NDREW R	AVE	R						Jul			95	5:50P.
		4. SOCIAL SECURITY NUM		5. SEX	8. AGE (in yrs. lesi	birthday)	IF UNDER		IF UNDER		7. DATE	OF BIRTH		8. BIRTH	PLACE (State or Foreign
P		218-32-57	67-A	1 🔀 M 2 🗆 F		81	YRS,	MONTHS	DAYS	HOURS	MIN.	Dec	th, Day, Year)	.913	Mar	yland
3 should	(C.	90. FACILITY NAME (# not k			r L						ION OF DEA	ATH		9c. COUN		
6 ,	DIRECTOR	Westminst Convale:	scent EDENT	Center		_		wes	cm.	inst	er			Ca	arro) T T
Pages	I W	10e. STATE	10b. COUNT	Υ			10c. CIT	Y, TOWN O	R LOCA	TION						10d. INSIDE CITY
-E		Maryland		Carrol.	1			West	mir	nste	r					LIMITS?
t permit.	FUNERAL	10e. STREET AND NUMBER							10	f. ZIP COD	_			_		HAT COUNTRY?
020 physician. burial-transit	E	1542 Old	<u> West</u>								1157				.s.	Α.
20 hysici urial-	교	11. MARITAL STATUS 1 Never Merried 2	Merried	12. WAS OECEDEN FORCES? 1	YES	2 □ ₹N	MED O	13. V	MAS DEC	CENDENT C	OF HISPANI In, Mexicen	C ORIGI	N? (Specify Yes Rican, atc.)	or No-	14, RACE Black	- American Indian, White, etc.
215-0020 attending physician se as the burial-tra	ВУ	3 Widowed 4 Dive		IF YES, GIVE W	AR OR O	ATES		1	YES	2 X NO	Specify:		Carrier Co.		Specif	White
	E		EDENT'S EDU			18e. DE0	CEOENT'S	USUAL OC	CUPATR	ON ost of working	-	16b. KINO OF BUSINESS/INDUSTRY				
	LET	Elementary/Secondary (College (1-4 or 5	+)	life.	Do NOT us	e retired.)		AST OF WORKI	''V	AGRICY-TUME				
AND 2 the hospital detached to	COMPL	17. FATHER'S NAME (First, A				-							Tu	TE		
MARYLAND retained by the hospit should be detached notified at once.	ECC	Andrew J	,,	n Raver			18. MOTHER'S NAME (First, Middle, Melden Surneme) Bessie Yingling									
MAR retained to 5 should notified	00	19e. INFORMANT'S NAME (196	MAILING	ADDRESS	(Street)	and Mumba	or Print De	and Alexander	A Oh		Code				
be reta ge 5 sh e noti	2	Grace D.	Grace D. Raver								inst	er	Pike,	West	min	ster,Md.
W - 60 - D		20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of										vn, State				
MORI ge 6 may lirector, p		4 Donation 5 Other	Surfel 2 Cremation 3 Removal from State Cemetery, crematory or other place) Constion 5 Other (Specify) Evergreen Mem. Gardens 7/21 Finksburg, Cemetery, crematory or other place) Evergreen Mem. Gardens 7/21 Finksburg, Cemetery, crematory or other place) Evergreen Mem. Gardens 7/21 Finksburg, Cemetery, crematory or other place) Cemetery, crem											Md.		
death. Page tuneral direct.		21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE								ILITY]	FLETCE	IER I	TINE	RAL HOME
0 - 0		23. PART t. Enter the displaces, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reappratory errest,												ter,Md.		
O to DE S		23. PART t. Enter the d	ases, or o	complications the	ceused	the dec	th. Do n	ot enter	the mo	de of dy	ing, such	as cen	diec or reepi	ratory srre	st,	Approximate
a of E		IMMEDIATE CAUSE (Final												interval Between		
hin math		disease or condition resulting in death)	→	Me	179	+A	he	Car	RC	l has	na a	0/	Pro:	stat	C	SHE 2.19
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OX 687 e be executed sician and corridor to burial, traumatic e	NO	Sequentielly list condit	ions,	b	(OD 40 4	0011050										
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phy phy ane p	음	CAUSE (Diseese or injuthat initiated events	7	OUE TO	(OR AS A	CONSEO	UENCE OF									
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2 2 4 2	CAL	PART ti. Other significa	condition	s contributing to		-	~ /		derlying	g cause g	given in P	ert I.	24a. WAS AN A PERFOR		24b.	WERE AUTOPSY FINOINGS AVAILABLE PRIOR TO
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w requires that been signed I pt. of Health a shows any	Σ	DID TODACCO II	CE CONITI	3 FIR						1		-		,		1 TYES 2 NO
Law law Dept	PHYSICIAN:	DID TOBACCO U 25. WAS CASE REFERRED TO		KIBUIE IO CA				H (Check or		JUNC	ERTAIN					
- F et e	Si	EXAMINER?	J MEDICAL	HOSPITAL:	N. STILL SERVE	J. C. C. C.		QTHER	:							
CIA ICIA	Η	27. MANNER OF DEATH		1 Inpatient 2 I	INJURY	etient 3	28b. TIME		ing Hom 28c. INJ		eldence 8	_				
NG PHYS frer this ceath with marked		1 Netural 5	Pending	(Month, De	ty, Year)		INJ		WO	RK7		280. DE:	SCRIBE HOW IN	JURY OCCI	JRED	
J 5 4 5	D BY	3 Suleide	Investigation	28s. PLACE OF	FINJURY	— At hor	ne, farm, a	treet, facto				28f. LOC	ATION (Street or	nd Number o	v Rumi Br	uda Number
S affe S	밑		Could not be determined	building,	etc. (Speci	fy)						City	or Town, State)	ia riambor c		nue mannon,
S S S S S	7	290. CERTIFIER	IFYING PHYSIC	CIAN: To the best of	my knowle	edge, dan	th occurre	d at the tin	ne dete	and place	and due to	the ear				
東京は	DMPL															and menner ee stated.
HOSPI FUNE WITHIN	8	29h SIGNATURE AND TITLE				-					NSE NUMB		1			
TO THE HOSPI TO THE FUNEF TO THE WITHIN IMPORTANT:	8	7.0	3 4	Agn for	2						332		/ [ZYO. DATE	2//	Month, Pay, Year)
P P & E	2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETEO CAUS	E OF DEA	TH (ITEM	27) (Type.	Print)		<u></u>		10 1			//	(//)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flow man after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNEAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

										95	2	3265
	1 - FOR STATE REGISTRAR	STATE OF N					EALTH AND DEATH	MENTA	L HYGIEN	_		
	1. DECEDENT'S NAME (First, Middle, Last)		^						OF DEATN		3.	TIME OF DEATH
	VIRGINIY	9 E.	1217	TEN	HO	USE	=	JU	XY /	4,19	YEAR /	:00P H
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. I	est birthday)	IF UNDER 1	_	IF UNDER 24 HRS.	7. DATE	OF BIRTH		8. BIRTHPLA	CE (State or Foreign
	216-46-7510	1 □ M 2)(X)	77	YRS.	MONTHS	DAYS	HOURS MIN.	June	20 19	918	Mary 1	and
-	9e. FACILITY NAME (If not institution, give				110		LOCATION OF D	EATH			TY OF DEATH	
DIRECTOR	SOUTHERN MARYLAN	D HOSPITA	AL CENT	ER	C	LINI	ON			PRINC	E GEO	RGE'S
	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	Y		10c, CIT	Y, TOWN OR	LOCATIO	ON				100	I. INSIDE CITY
1 8	Marvland Prin	ce George	, 1 ,									LIMITS?
	10e. STREET AND NUMBER	ce deor ge	3	1 AC	cokee		ZIP CODE			10a, CITIZ	EN OF WHAT	- /
FUNERAL	15504 Maple Driv	e					20607				USA	
5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. A	RMED	13, W	AS DECE	NDENT OF NISPAI	NIC ORIGIN	17 (Specify Yes	or No-	14. RACE — / Black, Wi	American Indien,
ВУ	1 Never Merried 2 Married 3 X Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES	M.O.	1 (YES 2	NO Specif	y:	rican, etc.)		Specify:	
	15. DECEOENT'S EQU	ICATION	10. 5	ECECENTIC.				100				White
	(Specify only highest grade	e completed)		Give kind of a le. Do NOT us	vork done du	ring most	of working	166	. KIND OF BUS	SINESS/INDU	STRY	
<u>a</u>	Elementary/Secondary (0-12)	College (1-4 or 5+	+}	ousew				١	wn Hor	ne		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				-	Т	18. MOTNER'S NA					
ш	Howard Sherwood	Sr				- 1	Unkn		made, malour	ourneme,		
0	19a. INFORMANT'S NAME (Type/Print)	<u> </u>	1	9b. MAILING	AOORESS (Street end	d Number or Rurai		ber, City or Tow	n. State. Zio C	Code)	
2	John M. Rittenho	use					rive Ac					07
	20s. METHOD OF DISPOSITION 1 N Buriel 2 Cremation 3 Rent 4 Donation 5 Other (Specify)		20b. PLACE	ANDDATE	E DISPOSIT	ION (Nam	e oi	DAT	E 20c 10	CATION C	Ity or Town	
			cemetery, c	ity Mo	emori	al G	ardens	7-20	-95 Wa	ldorf	. MD	
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSUE	M00		22. N/	AME AND	ADDRESS OF FA	CILITY	J.H.	berwe	jn Mo	rtuary D 20695
	Volunty 7	lem -		1/3	44	33 M	hite Pl	ains	La Wh	rite P	Is, M	D 20695
	23. PARY I. Enter the diseases, or	complications that	t ceused the d	leeth. Do r	ot enter th	ha mode	of dving, suc	h as card	lac or respi	ratory arre-	et. I	Approximate
	shock, or heart fellure. IMMEDIATE CAUSE (Fine)	List only one cau	se on each lin	ie.								Interval Between
	disease or condition	n	notas	24-	40		clon		2 22		ł	Onaet end Death
	resulting in death)	a. OUE TO	(OR AS A CONSI	EOUENCE OF	7.C		0/0//		21)00	-/		
z		h									j	
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate	DUE TO	(OR AS A CONS	EOUENCE OF):							
8	cause. Enter UNDERLYING CAUSE (Disease or injury	c									Į	
#	thet initieted eventa	DUE TO	(OR AS A CONSE	OUENCE OF	7):							
H	Tesuting in death) CAST	d										
	PART ii. Other aignificent condition	s contributing to	daeth but not	resulting i	n the unde	erlying	ceuse given in	Part i.	24s. WAS AN	AUTOPSY	24b. WEF	RE AUTOPSY FINDINGS
MEDICA							2000		PERFOR			LABLE PRIOR TO
밀								_	1 YES 2	(L) NO		DEATH?
2	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	ATH YE	SΠN	0 17	UNCERTAIL	<u>, </u>			1 1	YES 2 NO
IA	25. WAS CASE REFERRED TO MEDICAL			CE OF DEAT			OTTERNAL	, ,				
SIC	EXAMINER?	HOSBITAL:	ER/Outpatient	3 DOA	OTHER:	na Nome	5 Residence	8 □ Othe	(Specify)			
PHYSICIAN:	27. MANNER OF OEATN	28e. OATE OF (Month, Da	INJURY	28b. TIM	E OF 2	8c. INJUF	TA Y		CRIBE HOW II	NJURY OCCU	RED	
ВУ	1 Natural 5 Pending 2 Accident Investigation	(MONO), De	ay, remin	INJ	M	WORK	S 2 NO					
	3 Suicide 8 Could not be	28e. PLACE OF building.	F INJURY — At h	ome, ferm, s	treet, factor	y, offica		28I. LOC	ATION (Street e	nd Number or	Rural Route	Number,
13	4 Homicide datermined							Crity i	or rown, State)			
COMPLETE	290. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of	my knowledge, d	eath occurre	d at the time	e, data er	nd place, and due	to the ceu	se(a) and man	ner se stated		
OM	one) 2 MEDICAL EXAMINE											manner as stated.
Ŭ	296. SIGNATURE AND TITLE OF CERTIFIER						P9c. LICENSE NUN					th, Day, Yeer)
ω	Variables	1				1	D 45		,		- 1 .	
임	30. NAME AND AGORESS OF PERSON WIN	O COMPLETED CALIS	E OF DEATH //TE	M 27) (Tenn	Print)		VTJ	70		5/0	<u> </u>	4,1995

MD 37/0 7
32. BEGISTRAP'S SIGNATURE,
JULY OF WILLIAM RONDOLL



DIVISION OF VITAL RECORDS, P.O. BOX 68760 ST. BALTIMORE, MARYLAND 21215-0020

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

		1. DECEDENT'S NAME (First,	A district and a			UL	NIII (CALL	. 01	DEA	111	_	REG. NO.			
		Will		Leroy	Rudi	isill						2. DATE			YEAR 3	7:40 Pm
		4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE	(In yrs. last	birthday)	IF UNDER	_	IF UNDER		7. DATE	OF BIRTH	1	B. BIRTHPL	LACE (State or Foreign
D		220-28-3331	L	1 🔀 M 2 🗆 F	65		YRS.	MONTHS	DAYS	HOURS	MIN.	July	4, 19	930 N	Maryl	and
3 should		9e. FACILITY NAME (If not in	stitution, give s	treet end number)				9b. CITY,	TOWH	OR LOCATI	ON OF D			9c. COUNT	TY OF DEA	TH
89	DIRECTOR	Washingto	on Cou	ntv Hosp	ital			Н	lage	ersto	wn			Wash	ningt	on
	[[RESIDENCE OF DEC	10b. COUNTY				40 000									
Page	E .					l	10c. CITY	r, TOWN O								IOd. INSIDE CITY LIMITS?
Ĕ		Maryland 100. STREET AND NUMBER	was	hington						rstor						X YES 2 NO
physician. burial-transit permit. Pages 1, 2,	RAL	633 Marion	Ctwoo	4						2174	_			-		AT COUNTRY?
trans	FUNER	11. MARITAL STATUS	Stree	12. WAS DECEDEN	IT EVED II	NII C ADM	50	40.19						USA		
physician. burial-tran		1 Never Married 2	Merried	FORCES? 1	YES	2 X NO)	lf lf	yes, s	pecify Cuba	ın, Mexica	en, Puerlo R	? (Specify Yes lican, etc.)	or No 1	Black, V	– Americen Indien, White, atc.
	ВУ	3 Widowed 4 Divo	rced	IF TES, GIVE	man on D	MIES		'	U YES	S 2 X NO	Specif	ry:			Specify:	White
attending se as the	G	15. DEC	EDENT'S EDU	CATION COMPleted		16a. DEC	EDENT'S	USUAL OC	CUPATI	ION ost of working		16b.	KIND OF BUS	INESS/INDU	STRY	
al or after	Ē	Elementary/Secondary (0		College (1-4 or 5	+)	life. L	Do NOT use	e retired.)	unny m	OST OF WORK!	ng					
the hospital detached fo	COMPL	12				d	rive	r					tax	i		
9 8 E	흥	17. FATHER'S NAME (First, Mi								18. MOT			liddle, Meiden S	Surname)		
व व व	BE	Bruce Ma		Rudisill	L, Sr					Dori		Laver		niper		
retained b 5 should	2	19e. INFORMANT'S NAME (7)										-	er, City or Town			
		Herbert		disill		Rt	. 2	Box	3	012	Inwo	ood,	West V	irgin	ia 2	25428
beath. Page 6 may be funeral director, page xaminer must be		20a. METHOD OF DISPOSITI	n 3 🗆 Reme	oval from State	20b	PLACE AN	DDATEO	F DISPOSI	TION (N	ame of		DATE		CATION — CI		
age 6 direct	j	4 ☐ Donalion 5 ☐ Other 21, SIGNATURE OF FUNERAL			_ Ro	ose H	111		_			7/2	5 Hage	erstow	m, M	iaryland
death. Pag tuneral di I.		21, SIGNATORE OF FUNERAL	SERVICE LIC	ENSEE						A N			305	N Po	toma	c Street
		Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland														
8 7 E 9		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between														
		SHOCK, Or haart tailure. List Dnly ona Causa Dn each lina.													Intarval Between Onset and Daath	
withwest, pletely fille cremation, rent, the		disease or condition resulting in death)	→				lu	rec	da	elu	-					weeks
completely ial, cremati				DUE TO	(OR AS A	CONSECU	JENCE OF): (0				e			
executed and com o burial, matic ev	Z	disease or condition resulting in dasth) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												8 mos		
e be execute sician and c rior to buria traumatic	CATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSCOURNER OF).												0 "		
e by		cause. Entar UNDERLYING CAUSE (Disease or injury c. Veral Republic - suspected 9												7000		
Jeath certificat attending phy mal Hygiene p	CERTIFI	that initiated events DUE TO (OR AS A CONSEQUENCE OF):														
the atten Mental	핑			d												-
= 0 =	AL.	PART ii. Othar aignificat	nt condition	s contributing to	death b	ut not rea	aulting in	n tha und	Jarlyin	g cause g	given in	Part i.	24a. WAS AN / PERFORI			ERE AUTOPSY FINDINGS
that the ar	MEDICAL		diale	ite mel	litra	- Ru	ld						1 YES 25	,	CI	DMPLETION OF CAUSE F DEATH?
quires n signe f Healt	WE												_ /			YES 2 NO
e law req has been Dept. of 23 sho		DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE O	F DEAT	H YE	S 🗆 N	OD	J UNC	ERTAII	N 🗆				
N: The lan ficate has State Dep Item 23	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:		26. PLACE										
DR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate h nours after death with the State C tem 28 is marked, or Item	YSI	1 TES 2 NO		1 Sinpatiant 2	ER/Outp	etlent 3		OTHER:		ne 5 🗆 Re	sidenca	8 🗆 Other	(Specify)			
PHYSIC this ce with th	H	27. MANNER OF DEATH 1 Natural 5 1	D 41	26e. DATE OF (Month, D			28b. TIME INJU	OF :	28c. IN.	JURY AT ORK?		26d. DE\$(CRIBE HOW IN	JURY DCCU	RED	
DING PHYS After this death with	Æ		Pending Investigation					М		YES 2	NO					
TTENDII TOR: A after de			Could not be	28e. PLACE O building,	etc. (Spec	— At home	e, farm, at	treel, fector	ry, offic	e		28f. LOCA City o	TION (Street er r Town, State)	nd Number or	Rural Rout	te Number,
DR ATTENDING DIRECTOR: After hours after deat Item 28 Is ma																
TAL DR AL DIRECTOR POURS	교			CIAN: To the best of												
OSPIT JNER Thin 7	COMPLETED	2 MEDI	CAL EXAMINE	R: On the basis of e	xamination	n and/or Im	restigation	, In my op	inion, c	death occur	ed at the	time, date o	end place, end	dus to the	ceuse(s) er	nd manner es stated.
TO THE HOSPI TO THE FUNER be filed within	BE (29b. SIGNATURE AND TITLE	7 -							29c. LICE	NSE NUN	MBER		29d. DATE S	SIGNED (M	fonth, Day, Yeer)
TO THE HOSPITAL C TO THE FUNERAL C be filed within 72 h	0	Howldn)					7	1219	74		> 1	'-ZZ	-91
	-	30. NAME AND ADDRESS OF	-	7 . 1		ATH (ITEM	27) (Type, i	Print)	11	_	11-			_	0. 1	
		MINISOLD K	LITE		ms		348	m	11	51	HAZ	sep81	Down	v 1	nd	27740
_	ļ	JUL 2 5 1999	Jal.	B2. REGISTRA	SIGN.	ATURE L.										
			0			V										

X

White

taxi driver 12

Bruce Martin Rudisill, Sr. Doris Laverne Kaniper

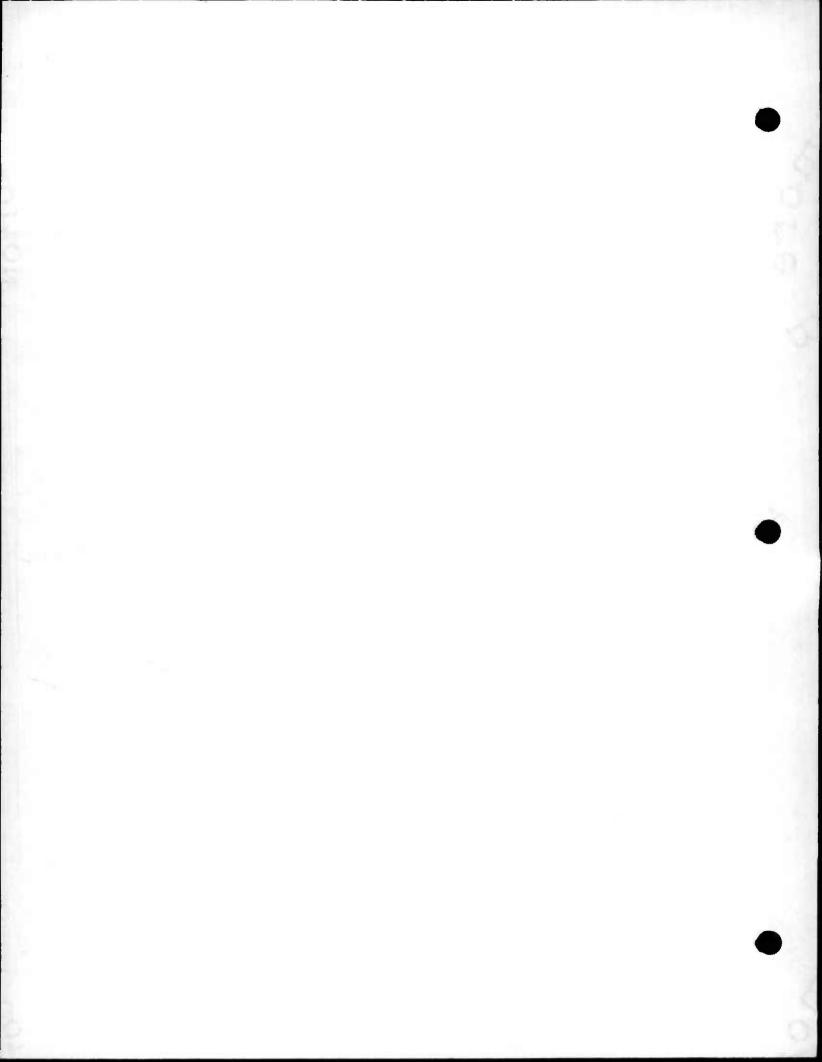
Herbert C. Rudisill Rt. 2 Box 3012 Inwood, West Virginia 25428

X 7/25 Hagerstown, Maryland Rose Hill Cemetery

Gerald N. Minnich 305 N. Potomac Street

Funeral Home Hagerstown, Maryland

		1 - STATE REGISTRAR	STATE OF N		/ DEPAI ERTIF							E		
_		1. DECEDENT'S NAME (First, Middle, Last)			ENIII	ICATE	UF	DEAI	П	2. DATE OF	REG. NO.			3. TIME OF DEATH
		Naomi Pearl RUI	OUTH							July	20		YEAR	9:02 P
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDER	1 YEAR	IF UNDER	_	7. DATE OF		1995	4 DIDTUD	LACE (State or Foreign
		173-03-3598	1 🗆 M 2 😾 F			MONTHS	DAYS	HOURS	MIN.	(Month, D	lay, Year)	^	Country	
should		9a. FACILITY NAME (If not institution, give	Λ	88		95 CITY	TOWN	R LOCATIO		Oct.	1 19		Mary.	
es Se	Œ									un.				
1, 2,	DIRECTOR	16735 Buford Di	rive			W	illi	amsp	ort			Wasl	hingt	on
Sec	띭	10a. STATE 10b. COUNT	Υ		10c. CI1	Y, TOWN O	R LOCAT	ION						10d. INSIDE CITY
permit. Pages	ā	Md. Washi	ington			Wil	liam	spor	t					LIMITS?
регш	A.	10e. STREET AND NUMBER						ZIP CODE				10g. CITIZ		HAT COUNTRY?
ışı	띪	16735 Buford Di	rive					217	95			TT (S.A.	
215-0020 attending physician. se as the burial-transit	FUNERAL	11. MARITAL STATUS	12. WAS DECEOEN	T EVER IN U.S.	RMED	13. \	WAS DECI	ENDENT O	F HISPANI	C ORIGIN? (Specify Yea		14. RACE	- American Indian,
P 4 2	BY F	1 Never Married 2 Married	IF YES, GIVE W	YES 2 X	NO			cify Cubar 2 ₹ NO		, Puerlo Rica	in, atc.)	10.0		White, etc.
ending as the		3 Widowed 4 Divorced							1 2557			_ [Wh	ite
21215-0020 al or attending physic for use as the burial	ETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. C	ECEDENT'S	USUAL OC	CCUPATIO	N st of workin	а	16b. KI	ND OF BUS	INESS/IND	USTRY	
212	<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+	·) #	'Give kind of fe. Do NOT u	se retired.)	auting into	A GO WOOTHING	y					
AND 2 the hospital detached to once.	MP	8	00		Ho	mema	ker			He	r own	home	9	
LAN the hor	COMPL	17. FATHER'S NAME (First, Middle, Last)						16. MOTH	IER'S NAM	E (First, Midd	de, Malden S	Surname)		
> 6 € € <	BE	Abraham Martin							Eliza	abeth	Shan	k		
MAR retained 5 should	0	19a. INFORMANT'S NAME (Type/Print)		1	9b. MAILING	ADDRESS	(Street ar	nd Number	or Rural Ad	oute Number,	City or Town	State, Zip	Code)	
2 2 2	-	I. Martin Rudol	.ph		16735	Buf	ord	Driv	e W	illia	nspor	t, Mo	1. 21	795
	1	20a. METHOD OF DISPOSITION 1X Burlai 2 Cremation 3 Rem	owal from State	20b. PLACE	E AND DATE	OF DISPOS	ITION (Na	me of		OATE	_	ATION — C		
AOR pe 6 ma rector, p		4 Donation 5 Other (Specify)	TOWN STATE	Broad	fordi	ng C	emet	ery	7-24	4-95	Hage	rstov	m. M	laryland
TIM Page ral dire		21. SIONATURE OF FUNERAL SERVICE LI	CENSEE	24	0	22. 1	NAME AN	O ADORES	S OF FACI	Min	nich	Funer	ral H	Ome
		> SCATTY	Min	med	2	4	15 E	. Wi	1son	Blvd	Нас	eret	מעדים	Md. 21740
		22 PART I Enter the diseases as		77-21		_								Md. 21/40
K 5 - 2		23. PART I. Enter the diseases, or ahock, or heart failure.	List only one ceu	se on each iir	iesth. Do i ie.	not enter	the mod	de of dyli	ng, such	as cerdied	or respir	atory srre	et,	Approximete Interval Between
		IMMEDIATE CAUSE (Final disease or condition	0	- 0 1	0	į.		2	1.	- 4				Onaat and Death
of within a smpletely fille cremation, the		resulting in death)	•	ardio (OR AS A CONS Cerus	yeurs	non	ary	/	ww	est				
			OUE TO	(OR AS A CONS	EQUENCE O	F):	11	11.	- N	Dea.	10-0			18 Mans
executed and con o burial, matic e	S	Sequentially list conditions,					1	Mai	u	NO C	wo			1
a can be	CATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CONS	EQUENCE O	F):								
icate be physicia prior le pri	일	CAUSE (Diseese or Injury	c.	OR AS A CONS	EQUENCE O	.								
certifica ding phy lygiene other	RTIFI	that initiated events resulting in deeth) LAST	502 10	(ON AS A CONSI	EOUENCE O	ej:								i
S, P.O. BC death certificate attending physiental Hygiene pri	ä		d											
S = 4 ≥ =		PART II. Other significent condition	s contributing to	deeth but not	reaulting	In the un	derlying	ceuse g	Iven In P	art I. 24	a. WAS AN A	WTOPSY	24b. V	VERE AUTOPSY FINOINGS
that the the the and the and Ind	MEDICAL										PERFORM			WAILABLE PRIOR TO COMPLETION OF CAUSE
Sign Sign										- '	YES 2	NO		OF DEATH?
HEC v requires been sign ft. of Hea shows		DID TOBACCO USE CONT	PIRLITE TO CAL	ISE OF DE	ATLI VI	:C 🗆 N	и П	UNIC	ERTAIN				1	YES 2 NO
13 e s a L	SICIAN:	25. WAS CASE REFERRED TO MEDICAL	NIBOTE TO CA		CE OF DEA			UNC	EKIAIN					
N: The ficate h State (2	EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER	t:	1/	/					
SICIAN: The certificate the State	РНҮ	27. MANNER OF DEATH	1 Inpatient 2 I		28b. TIM		ing Home 28c. INJU		-	Other (S				
S His E		1 Natural 5 Pending	(Month, Da			URY	WOR	RK?		26d. DEŞCR	BE HOW IN	JURY OCC	URED	
After death	B	2 Accident Investigation	200 DI ACE OF	E IM II IMV A. A.	1 1 1 1 1 1	<u>"</u>		ES 2 🗌	100					
TTEND TOR: /		3 Suicide 6 Could not be 4 Homicide determined	building,	F INJURY — At h etc. (Specify)	iome, term,	atreet, facto	ory, office			28t. LOCATIO	ON (Street ar own, State)	d Number o	or Rural Roi	ute Number,
OR ATTEN DIRECTOR: hours after item 28 1	山					-		_						
TAL DR AL DIRE 72 hours	COMPLE		CIAN: To the best of											
HOSPITAL FUNERAL Within 72 I	0	one) 2 MEOICAL EXAMINE	R: On the basis of ex	amination and/or	Investigation	n, in my op	pinion, de	eth occure	d at the ti	me, date and	d place, and	due to the	Cause(a)	and manner as stated.
E FU d wit		296 SIGNATURE AND TITLE OF CERTIFIE	RA					29c. LICEI	NSE NUMB	IER /	T	29d. DATE	SIGNED /	Agrith, Day, Wear)
TO THE HOSPIT TO THE FUNERA De filed within 7	В	Has	Thedrahe	2				02	7894			D 7	124	91
F F A =	2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUS	E OF DEATH (IT	EM 27) Type	Print)	_	11	- "	_			- 1	
		FRANCISCO L	ANDR	A08.	41	LLS	7.	HAG	dest	TOWK	1,1	40	217	40
		31. DATE FILED (Month, Day, Year)	32. REGISTRAI	R'S SIGNATURE									_	
		JUI 2 5 1995	The Asimila	an Rod 1	,									
		701 2 7 1000	my so money	TO BE THE OWNER OF THE PARTY OF	6									



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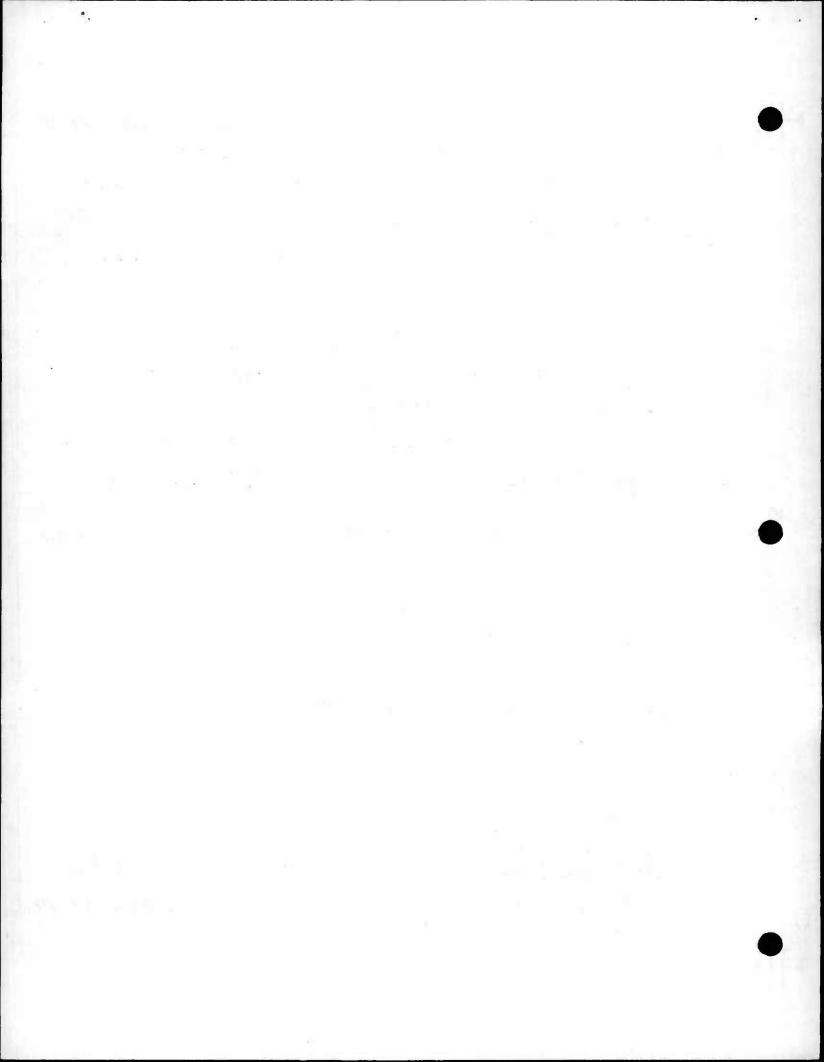
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burkal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burkal, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

6

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL	HYGIENE
CERTIFICATE OF DEATH		REG. NO.

1	FOR STATE REGISTRAR	STATE OF MARYLAN	ND / DEPART	MENT OF H	EALTH AND I	MENTAL HYGIENI REG. NO.	E	
		PEARL ROBINS	SON			2. DATE OF DEATH DA	Y /99	3. TIME OF DEATH 14. 30 M
		6. AGE (In 78		F UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec. 18 19	6. BIR Cou	THPLACE (State or Foreign ntry)
1 19	9e. FACILITY NAME (If not institution, give street				R LOCATION OF DE		9c. COUNTY OF	
Š.	Dorchester G	General Hospi	tal	Ca	mbridge		Dorche	ster
	Maryland Do	rchester		nbridge	ON			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	10e. STREET AND NUMBER 2606 Brian	Circle		107.	ZIP CODE 21613	3	10g. CITIZEN OF	WHAT COUNTRY?
D. I	11. MARITAL STATUS 1	2. WAS DECEDENT EVER IN U FORCES? 1 YES	ARMED	13. WAS DECE	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yee n, Puerto Rican, etc.)	or No- 14, RA	CE — American Indian, ock, White, efc.
} 8	1 Never Married 2 Married 3 XWIdowed 4 Divorced	IF YES, GIVE WAR OR DATE	s	1 TYES	2XX NO Specify	r:		white
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade col Elementary/Secondary (0-12)	rion mpleted) College (1-4 or 5 +)	Give kind of wo life. Do NOT use	rk done during mos	N t of working	18b. KIND OF BUS	INESS/INOUSTRY	
" PP	9	Dollage (1-4 or 5 +)	crab	picker		seafood	packing	
BE COI	17. FATHER'S NAME (First, Middle, Lest)	in Jones				ME (First, Middle, Maiden S Millie Mer		
	Mrs. Yvonne James					Route Number, City or Town		
	20s. METHOD OF DISPOSITION	20b. Pf	ACEAND DATEOR			mbridge MI	ATION — City or	Town State
	1. Suriel 2 Cremetion 3 Remova 4 Donation 5 Other (Specify)	I from State Comete	n U.M.	Churchya	rd Jul	y 21 Todd	ville M	
	TI, SIGNATURE OF TWEERAL SERVICE LICEN	SEE		Thoma	S Funera	1 Home	- MD 01	612
	23. PART I. Enter the diseases, or con	npilcationa that caused ti	na daath. Do no			. Cambridg		Approximata
	shock, or haart fallure. Lis iMMEDIATE CAUSE (Final disease or condition			4				Intarval Between Onset and Daath
	resulting in death)	Heart DUE TO (OR AS A CO		ure				6 H13
No.	Sequantially list conditions, b.	OUE TO (OR AS A CO	Mesousues AD					
CAT	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury		onoccusion of j.					
	that initiated events resulting in death) LAST	OUE TO (OR AS A CO	ONSEQUENCE OF):					
5	PART II. Other significant conditions of	contributing to death but	not resulting in	tha underlying	cause givan in	Part i. 24e, WAS AN A	MITOPSY 24	h WERE AUTOPSV EINDINGS
	PART II. Other significant conditions of	contributing to death but	not resulting in	tha underlying	cause givan in	Part i. 24e. WAS AN A PERFORI	WED?	b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
I: MEDICAL	Colon	Cancer				PERFORI	WED?	AMILABLE PRIOR TO COMPLETION OF CAUSE
CIAN: MED	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF	DEATH YES	Ocheck only one)		PERFORI	WED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
IYSICIAN: MED	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	BUTE TO CAUSE OF 26. COSPITAL: A Inpatient 2 DER/Outpetk	DEATH YES	Check only one) THER: Nursing Home	UNCERTAIN 5 □ Rasidence	PERFORI 1 YES 2	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN:	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	BUTE TO CAUSE OF 26.	DEATH YES	(Check only one) OTHER: Nursing Home OF 28c. INJU	UNCERTAIN 5 □ Residence	PERFORI	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN:	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 17. MANNER OF DEATH	BUTE TO CAUSE OF 26. CSPITAL: R Inputtent 2 = ER/Outpatte 28a. OATE OF INJURY	PLACE OF OEATH on 3 DOA 4 28b. TIME 0	(Check only one) OTHER: Nursing Home Nursing Home OF 1 Yes	UNCERTAIN 5 □ Residence RY AT IK?	PERFORI 1 YES 2	JURY OCCURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN:	DID TOBACCO USE CONTRIE 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 17. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	BUTE TO CAUSE OF 26. CSPITAL: Inpatient 2 = ER/Outpatte 28a. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY — building, etc. (Specify)	DEATH YES PLACE OF GEATH OF 1 DOA 4 28b. TIME INJUE At home, farm, atro	(Check only one) OTHER: Nursing Home OF WOR M 1 YE Bet, factory, office	UNCERTAIN 5	PERFORI 1 YES 2 6 Other (Specify) 26d. DE\$CRIBE HOW IN City or Town, Stete)	JURY OCCURED	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN:	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 17. MANNER OF DEATH 2 Accident Investigation 3 Suicide 6 Could not be determined 19a. CERTIFIER (Check only) 1 CERTIFYING PHYSICIA	BUTE TO CAUSE OF 28. OSPITAL: Inpatient 2 = ER/Outpath 28a. OATE OF INJURY (Month, Day, Year)	DEATH YES PLACE OF OEATH PM 3 DOA 4 28b. TIME (INJUR At home, farm, atm	(Check only one) OTHER: Nursing Home Nursing Home WOR M 1	UNCERTAIN 5	PERFORI 1 YES 2 6 Other (Specify) 26d. DESCRIBE HOW IN City or Town, Stete)	JURY OCCURED and Number or Rural over as stated.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
D BE COMPLETED BY PHYSICIAN:	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	BUTE TO CAUSE OF 26. COSPITAL: Inpatient 2 ER/Outpette 28a. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Specify) N: To the base of my knowledge On the base of axamination as	PLACE OF OEATH ont 3 DOA 4 28b. TIME (INJUE At home, farm, atm	(Check only one) OTHER: Nursing Home OF WOR M 1 YE set, factory, office at the time, date a	UNCERTAIN 5	PERFORI 1 YES 2 6 Other (Specify) 26d. DESCRIBE HOW IN 28f. LOCATION (Street er City or Town, Stete) to the cause(e) end menr	JURY OCCURED and Number or Rural there as stated.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
D BE COMPLETED BY PHYSICIAN:	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	BUTE TO CAUSE OF 26. COSPITAL: Inpatient 2 ER/Outpette 28a. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Specify) N: To the base of my knowledge On the base of axamination as	PLACE OF OEATH ont 3 DOA 4 28b. TIME (INJUE At home, farm, atm	(Check only one) OTHER: Nursing Home OF WOR M 1 YE set, factory, office at the time, date a	UNCERTAIN 5 Rasidence RY AT IK? ES 2 NO	PERFORI 1 YES 2 6 Other (Specify) 26d. DESCRIBE HOW IN 28f. LOCATION (Street er City or Town, Stete) to the cause(e) end menr	JURY OCCURED and Number or Rural there as stated.	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, (e) end menner as stated.



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BALTIMORE, MARYLAND 212	requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or at
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RECORDS, P.O. BOX 68760	e .
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR ROBERT W.STEWART JULY 995 3:25P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 468-18-3901 Feb. 7%, 1919 1 M 2 | F 76 DAYS Minnesota Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Prince George's Hospital Center Prince George's Cheverly RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland XX YES 2 NO Prince George's Bowie use as the burial-transit permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3617 Maroon Lane 20715 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 \square YES 2 \square NO IF YES, GIVE WAR OR DATES Yes 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-II yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. RACE - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 TYES 2 NO B 3 Widowed 4 Divorced Specify: White 60 15. DECEOENT'S EOUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KINO OF BUSINESS/INDUSTRY COMPLET ğ Elementary/Secondary (0-12) College (1-4 or 5+) detached Mechanical Engineer 5+ Aerospace/US Gov't Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 8 notified at Axel Friedman BE Hazel Appleby 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Duane Stewart 12604 Craft Lane Bowie, MD 20715 þe 20e. METHOD OF DISPOSITION
1 Burlal 242 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must funeral director, Metropolitati Crematory 7/15 Alexandria, Virginia 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AGORESS OF FACILITY Robert E. Evans Funeral Home, P.A. Kohert vans 16000 Annapolis Rd. Bowie, MD 20715 the removal medicai 23. PART I. Enter the diseases, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, in by Approximata ahock, or haart fallure. List only ona cause on each line. ŏ Intarval Between **IMMEDIATE CAUSE (Final** Onset and Death event, the disease or condition_ 11250112700 completely resulting in death) DUE TO (ON AS A CONSEQUENCE OF): and corr neumon. other traumatic CERTIFICATION Sequentially list conditions, 2 DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING 615 the attending physicial Mental Hygiene prior 0,16 tis CAUSE (Disease or injury DUE TO (GA AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS 함 AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMEO? shows any Signed Health a 1 YES 2 70 1 YES 2 NO been : DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN, PHYSICIAN: certificate has been the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: L OR ATTENDING PHYSICIAN: TI DIRECTOR: After this certificate hours after death with the State 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCUREO 28b. TIME OF 28c. INJURY AT this c marked, 1 Natural 5 Pending 1 YES 2 NO В 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, streel, lectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28 is 8 Could not be COMPLETED 4 Homicide determined 29e. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner ee stated. HOSPITAL FUNERAL (within 72 h = TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT. II 2 MEDICAL EXAMINER: On the mination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

CAUSE OF GEATH (ITEM 27) (Type, Print)

00

32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

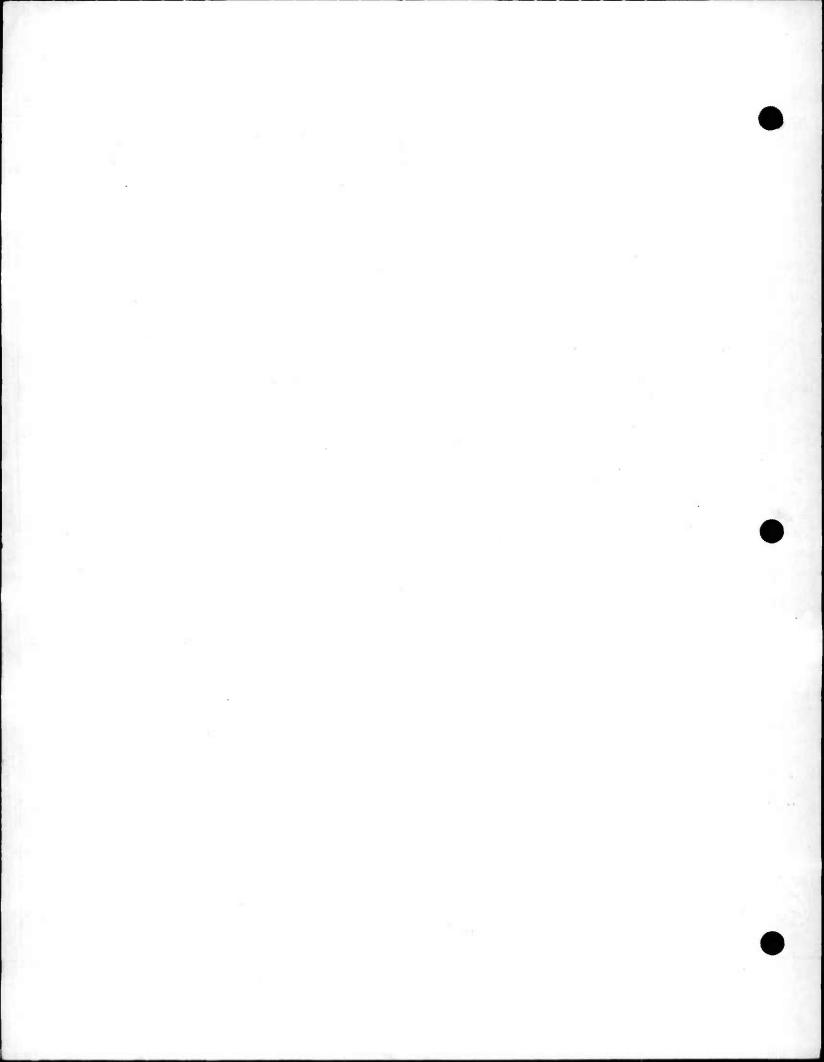
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30. NAME AND ADDRESS OF PERSON

9 1995

31. DATE FILEO (Month, Day, Year)

DIVISION OF VITAL

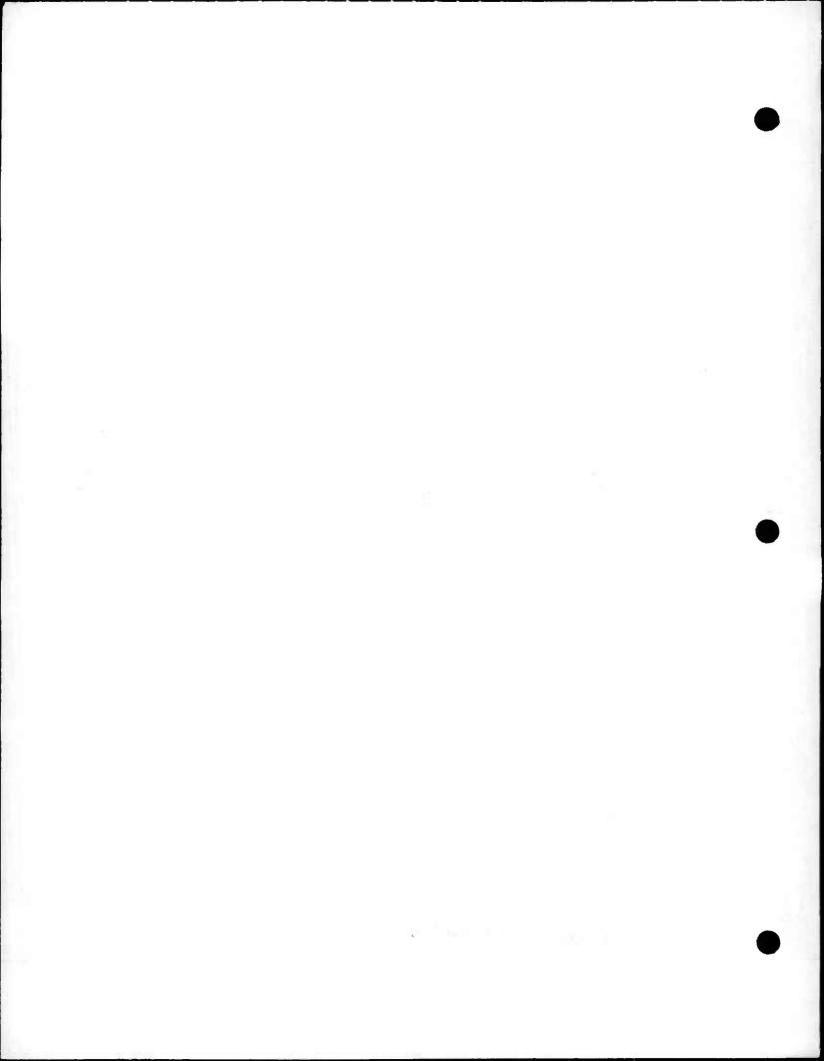


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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 -

	1. DECEOENT'S NAME (First	, Middle, Last)								2. DATE OF				3. TIME OF DEATN
Rea K. Smith July 11 DAY 1995 YEAR 7:4									7:40 P.M. M					
	4. SOCIAL SECURITY NUME	ER	5. SEX	6. AGE (In yrs. I	ast birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7 DATE OF E	нтн		B. BIRTH	IPLACE (State or Foreign
	579 16 6808	3	1 🗌 M 2 🖳 F	91	YRS.	MONTHS	DAYS	HOURS	MIN.	March	8,1	904	Counti	nnsylvania
	9a. FACILITY NAME (If not in	stitution, give str	reet and number)			9b. CITY	, TOWN	OR LOCATI	ON OF DE				NTY OF D	EATH
FUNERAL DIRECTOR	Meridian Nu	rsing	Center-S	Spa Cree	e k	Anr	napo	lis				Anı	ne A	cundel
m m	10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN C	R LOCAT	TION						10d. INSIDE CITY
5	Maryland	Anne	Arundel		E	dgewa	ater							LIMITS?
RAL	10e. STREET AND NUMBER							ZIP COD				1 22 6		VHAT COUNTRY?
N.	2746 Fenne	L Koad	12. WAS DECEOEN					2103					ted S	States
	1 Never Married 2	Merried	FORCES? 1	YES 2			If yes, sp	ecify Cuba	n, Mexica	NC ORIGIN? (Si n, Puerlo Ricer	pecify Yes i, etc.)	or No-	Black	American Indien, r, White, atc.
B	3 Widowed 4 Divo	roed	IF YES, GIVE W	AR OR OATES	No		1 TYES	2)(NO	Specify	N	0		Speci	^{y:} White
	15. DEC (Specify only	EOENT'S EDUC	ATION completed)	16a. C	ECEOENT'S	USUAL O	CCUPATIO	ON working	wi.	16b. KIN	O OF BUS	INESS/INC	DUSTRY	
COMPLETED	Elementary/Secondary (0	-12)	College (1-4 or 5 d	•)	Give kind of fe. Do NOT u		aumy mo	or or work	·¥					
MP	12			I	lomema	aker					Own 1			
8	17. FATNER'S NAME (First, M									ME (First, Middle	, Maiden	Sumame)		
H	Henry B. K		.n							Brown				
2				1						loute Number, C				
	Marilyn S.		.son	10000					Edge	ewater				
	1 Donation 8 Other	n 3 🗆 Remo (Specify)	12221	cametary, c	ramatory or o	of dispos ther place) LL Ce	eme t	ery 7	7/15/	95			City or To	wn, State Cyland
	21. SIGNATURE OF FUNERAL	L SERVICE LICE	HOEE)	22. T	NAME AN	O ADDRES	SS OF FAC	YLITY		1 1100	- T	λ .
}	Kolent	· C. (win	s. t	100					ans Fun Lis Rd				
	23. PART I. Enter the di	seasea, or co	omplications the	t caused the d	isath. Do	not enter	the mo	ds of dyl	ng, auch	as cardiac	or respi	ratory sri	rest,	Approximats
	IMMEDIATE CAUSE (Fin		and only one cau	se on eech lin	le. (Interval Between Onset and Daeth
	disease or condition resulting in death)	+ .	Mela	astal	10	Ca	40	ev -	- 50	ovrce	. (/	n K	roun	mante
			DUE TO	(OR 40 4 DONO)	ROUGHOF-O	7	_							
NO N	Sequentielly list conditi	ona, b.	Jev.	ere	ct	TF								yrs
CERTIFICATION	if any, leading to immediate. Enter UNDERLY		A	OR AS & CONSI	EQUENCE OF	2		110	7					4~
띮	CAUSE (Disease or inju- that initiated events	ry C	DUE TO	(OR AS A CONSE	EOUENCE O		10	110	1101	7				1/4 7
	reaulting in deeth) LAS'	r (L												Ì
	-11-10-11-11-11-11-11-11-11-11-11-11-11-							-						
MEDICAL	PART II. Other algolfica	nt conditiona	contributing to	death but not	resulting	In the un	derlying	cause g	lven in l	Part I. 24a.	WAS AN A		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă						_				_ 10	YES 2	NO	+	COMPLETION OF CAUSE OF DEATH?
E I														1 - YES 2 - NO
ÿ.	DID TOBACCO U		IBUTE TO CA					-UNC	ERTAIN					
PHYSICIAN	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:	26. PLA	CE OF DEAT	OTHER								
₹	1 YES 2 NO		1 Inpetient 2 I			4 Date		5 🗆 Ra	sidence (8 Other (Spe	cify)			
	27. MANNER OF OEATH	Pendina	28s. DATE OF (Month, De		28b. TIM	URY	_	RK?		28d. DEŞCRIB	E NOW IN	JURY OCC	CURED	
À	2 Accident	nvestigation	00- 01 405 01				1 U Y] NO					
		Could not be latermined	building,	F INJURY — At h stc. (Specify)	ome, farm, i	Hreet, facto	ory, office	1		26f. LOCATION City or Tox	l (Street si vn, State)	nd Number	or Rural R	oute Number,
٦	29s. CERTIFIER	FYINO PNYSIC	IAN: To the best of	my knowledge d	anth accurre	od at the ti	mo dete	and place	and due					
COMPLETED														and manner as stated.
ш	29b. SIGNATURE AND TITLE	OF CERTIFIER		1				29c. LICE	NSE NUM	BER		29d. DATI	E SIGNEO	(Month, Day, Year)
	10580	nt	rien	1	,			DI	79	65	-	17	7/14	195
۵ ا	30. NAME AND APPRESS OF	PERSON WHO	COMPLETED CAUS	E OF OEATH (ITE	EM (Type,	Print)		0	, ,	. 1		1		13
	31, DATE FILED (MININ, Day)	XX	11.	ulvi	7 2	05		X d	get	1 FV	۴.	B	nn	20 11, Wol.
	32, REGISTRAR'S SIGNATURE													

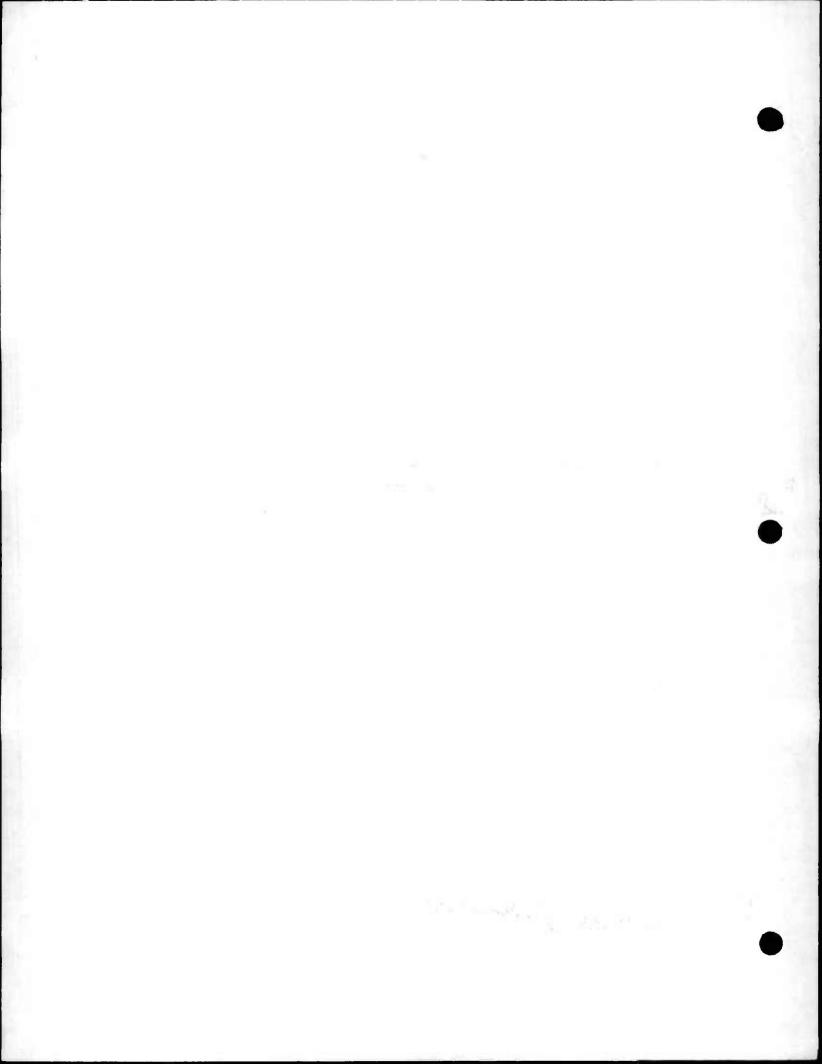
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



DIVISION OF VITAL RECORDS, P.O. BOX 68760 L. DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician L. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tra

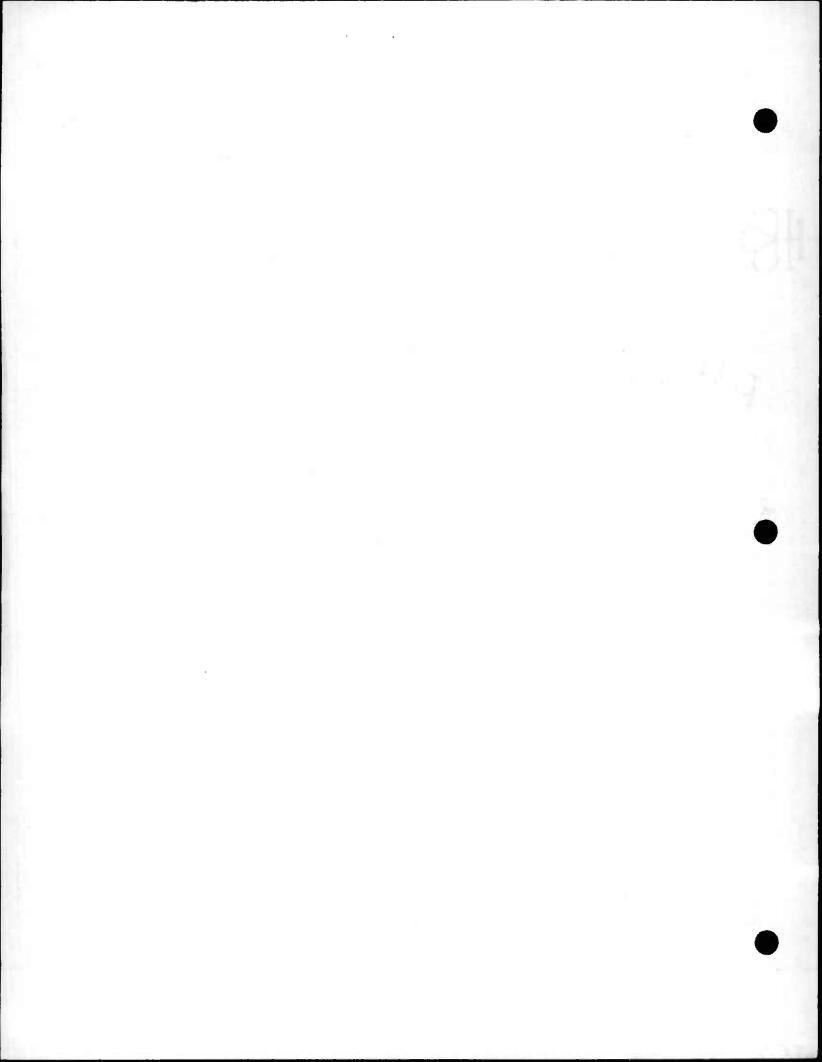
1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.

		HEGISTHAN			C	CHILIE	CATE	UF	DEATH		REG. NO			
		1. DECEDENT'S NAME (First,		0-						2. DATE	OF DEATH		3.	TIME OF DEATN
		SAMUEL	- Stt	ORT						2. DATE MONTH	07	12	95	145 PM
		4. SOCIAL SECURITY NUMB	ER	5. SEX 6	. AGE (In yrs. les	it birthday)	IF UNDER 1 Y	EAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH			ACE (State or Foreign
		228-18-3372)	1 🔲 M 2 🗌 F	77	YRS.	MONTHS D	AYS	HOURS MIN.		Day, Year)		Country)	
pino		9a. FACILITY NAME (If not in		reet and number)	77_		9h. CITY. TO	ww	OR LOCATION OF D		7 20.	1917	TY OF OEAT	rginia
3 should	CTOR	Charlotte H	1211 W	storanc He	\m_0				rlotte H					
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Oes) H	10e. STATE	10b. COUNTY			10c. CITY	, TOWN OR L	LOCA	TION				10	d. INSIDE CITY
~ ~	DIRE	Maryland	St	. Mary's			С	ha	rlotte H	lall			1	LIMIT\$?
E	AL	10e. STREET AND NUMBER						-	of. ZIP CODE			10g. CITIZ		T COUNTRY?
nsit .	FUNERAL	Route	2, Bo	x 5				ш	2062	22				l States
al-tra	S	11. MARITAL STATUS	,	12. WAS DECEDENT E	VER IN U.S. AR	MED	13. WAS	S DEC	CENOENT OF HISPA		(Specify Yea	L		American Indian.
Duri.		1 Never Married 2		FORCES? 1 []		10	If ye	18, SP	pecify Cuben, Maxic S 2 NO Speci	an, Puarto R	Ican, etc.)		Black, W	/hite, etc.
the sa	В	3 Widowed 4 Divo	reed				''	1 163	s z A NO Speci	ry.			Specify:	Black
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detach once.	COMPLET	17. FATNER'S NAME (First, Mi	ddle, Last)						18. MOTNER'S NA	AME (First, M	iddle, Maiden	Surname)		
2 %	- 1	Joe :	Short								nnie G		errv	
5 should	BE	19a. INFORMANT'S NAME (7)			198	b. MAILING	ADDRESS (St	treet a	and Number or Rural				J	
5 st	2	Jean	ette D	avis					er Dr., V				19801	
be bade		20a. METHOD OF DISPOSITI		2 7 20	20h PLACE		F DISPOSITIO				20c. LO			
boos and ocean, rage or may be treated by the inapplial of attenting physician. In by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages or removal. medical examiner must be notified at once.		f ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		wal from State			per place)			7/19/9			ield,	
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d in by th or remova		23. PART I Enter the di	seasea, or c	omplications that c	eused tha de	sth. Do no	ot anter the	a mo	ode of dyling, suc	h ss card	ec or respi	retory arre	et.	Approximats
		Tiock, of the	oit ielluie. L	ist only one cause	on each ilne							, , , , , , , , , , , , , , , , , , , ,		interval Between
y filled tion, or the m		IMMEDIATE CAUSE (Fin disease or condition resulting in death)		a. a.		· A 1	2				14 6	.1 . 25		Onset and Death
npletely fille cremation, vent, the	1 1	resulting in death)		COMPLI.	R AS A CONSEC	O /	3 VANC	6	YUR GAN	16 84	412 3	7~5 80	747	years!
signed by the attending physician and completely files is the attending physician and completely file theath and Mental Hygiene prior to burial, cremation, was any injury, or other traumatic event, the	_			332 13 (31	1 AD A CONSEC	DENCE OF	,.							
and o bun	5	Sequentially list condition		OUE TO (OI	R AS A CONSEC	LIENCE OF	١٠							
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s certificate has been s th the State Dept, of H d, or Item 23 shov	SICIAN:	EXAMINER?		HOSPITAL:			OTHER:							
the the	НХ	27. MANNED OF OEATN		1 Inpetient 2 I E				_	ne 5 🗆 Realdence	_				
DIRECTOR: After this c hours after death with item 28 is marked,	- 1		Pending	(Month, Day,	Ybar)	28b. TIME INJU	RY	WO	JURY AT	28d. DESC	RIBE HOW IN	IJURY OCCU	RED	
ther mar	B	2 Accident	rvestigation						YES 2 NO					
DR: A ter d	a		Could not ba	28s. PLACE OF II building, etc	NJURY — At hou . (Specify)	me, farm, st	reet, factory,	offic		28f. LOCA City or	TION (Street a. Town, State)	nd Number or	r Rural Route	Number,
RECTOR In 28		TO HOLLES												
L DIREC Pours	7	(Check only	FYING PHYSIC	IAN: To the best of my	knowledge, da	eth occurred	f at the time,	dsta	and place, and due	to the caus	e(a) and man	ner sa stated	1.	
FUNERAL within 72 P	COMPL			: On the basis of exam										d manner as stated.
TA WIT		29b. SIGNATURE AND TITLE		-					29c. LICENSE NUI					
TO THE FUNERA be filed within 7 IMPORTANT: I	BE	1 Hm +	4 1	Track in	7				7 3 / 6	P D		DATE:		onth, Day, Year)
F 8 3	2	30. NAME AND ADDRESS OF	PERSON WNO	COMPLETED CAUSE	OF OEATN /ITEM	27) (Time 4	Print)	_	1000	30		50	4 /	2,1995
711		FR Hall	11=5/	-				. ^	va		206	>	-	
		31. DATE FILED MORD, DO	W 1 9	A PRECISION S	SIGNATURE	ur	TOPI) (RICK, 1	4) -	200	()		
		JUL 20 18	0	The Inches Troops	Ardening One									
: 1														



FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

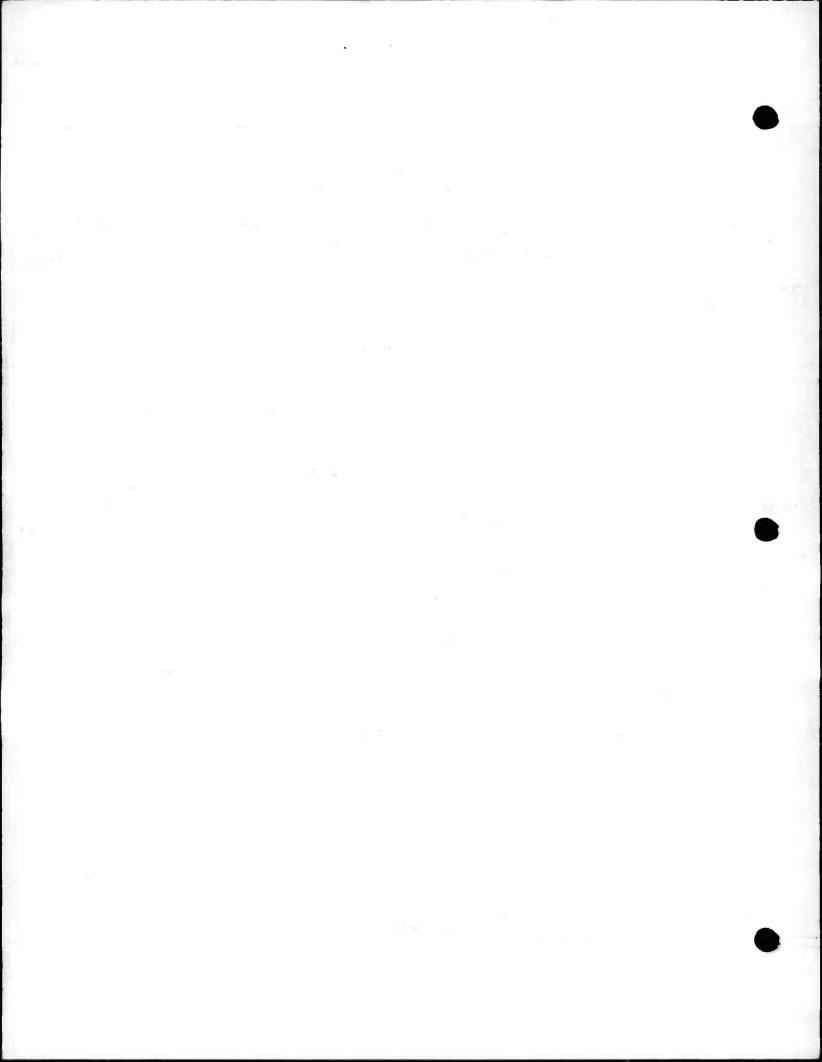
		REGISTRAR		CERTIF	-ICATE C	OF DEATH	REG. NO	١.				
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH D	AY YEAR	3. TIME OF DEATH			
v		MARGARET	М.		Sargent		July 4	1995 YEAR	11:14 A M			
Ti		4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	E (In yrs. last birthday)	IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH	9 8101	THPLACE (State or Foreign			
70		579-38-0915	1 □ M 2 💢 F	81 YRS.	MONTHS DA	YS HOURS MIN.	DEC . 29, 1	913 MA	RYLAND			
3 should		9a. FACILITY NAME (If not institution, give s	treet and number)		9b. CITY, TO	WN OR LOCATION OF D		9c. COUNTY OF				
2,3	8	MEMORIAL HOSPI	TAL		EAST	CON		TAL	вот			
₩.	DIRECTOR	RESIDENCE OF DECEDENT										
ages	뿚	10a. STATE 10b. COUNTY		10c. Cf	TY, TOWN OR LO				10d. INSIDE CITY LIMITS?			
permit. Pages			LBOT		EAS	LON			1 X YES 2 NO			
	IAL	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?			
n. ansit	🗓	501 DUTCHMAN'S	LANE			2160	1	USZ	A			
215-0020 attending physician. se as the burial-transit	FUNER	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 XYE	R IN U.S. ARMED	13, WAS	DECENDENT OF HISPA	NIC ORIGIN? (Specify Ye	or No- 14. RAI	CE — American Indian,			
P P	Β¥Ι	1 Never Married 2 Married 3 Widowed 4 X Divorced	IF YES, GIVE WAR OR	DATES		yes 2 NO Speci		Spe				
15-0 ending as the			NAVY						WHITE			
21215-0020 il or attending physic for use as the burial	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a, DECEDENT'S (Give kind of	work done during	ATION a most of working	186. KIND OF BU	SINESS/INDUSTRY				
		Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	ise retired.)	•						
AND. the hospit detached	월	11	5	EDUC	ATOR		PUBL	IC SCHO	OOL			
the hor detact	8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N	AME (First, Middle, Maiden	Surname)				
A A L	띪	CHARLES E. MC	RRIS			EMMA I	ROWINS					
MAR retained 5 should notified	5	19a. INFORMANT'S NAME (Type/Print)		19b. MAJLIN	G ADDRESS (Str	set and Number or Rural	Route Number, City or Tow	n, State, Zip Code)				
9e 5	-	CAROLYN M. COX		P.O.	BOX 3	3713, GRI	EENVILLE,	DE 198	307			
BALTIMORE, MARYLAND ter death. Page 6 may be retained by the hospit the funeral director, page 5 should be detached oral.		20a. METHOD OF DISPOSITION 1 To Burlel 2 Cremation 3 Remo	2	0b. PLACE AND DATE	OF DISPOSITION			CATION — City or 1				
O o o		4 Donation 5 Other (Specify)	JVBI from State	SPRING	HTT.L. (EMETERY		TON, MI				
ALTIM death. Page e funeral dire al.		21. SIGNATURE OF FUNERAL SERVICE LIC	C. O.			E AND ADDRESS OF FA	ACILITY					
VL7		ME New	70	CFST	NEW		ERAL HOME					
BA after of by the moval.		11/ W Men	succui		200	S. HARI	RISON ST.	, EAST	ON, MD			
hours after the in by the or removal		23. PART i. Enter the diseases, pro shock, pr heart fellure.	omplications that caus	ed the death. Do	not entar tha	mode of dying, suc	ch as cardiac or reap	ratory arrest,	Approximate			
hours filled in b on, or rer		IMMEDIATE CAUSE (Final	and only one occase on	outil inje.					interval Between Onset and Death			
		disease Dr condition resulting in death)	MT	Myocard	ial Inf	arction			1 HOUR			
		resulting in deatily	DUE TO (OR AS	A CONSEQUENCE O		arction			THOOK			
	z	-										
OX 68 e be execut sician and c nrior to buri	CERTIFICATION	Sequentially list conditions, If sny, leeding to immediate										
BOX icate be ex physician a er prior to	8	cause. Enter UNDERLYING										
O. B. ertificat ing phy rgiene p	Ē	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE O	P)							
V. PET P	듄	resulting in desth) LAST										
S, P ne death the atten Mental H njury, or	岁		7-									
	A	PART II. Other significant condition	s contributing to death	but not resulting	in the underl	ying cause given in	Part I. 34a. WAS AN PERFOR		b. WERE AUTOPSY FINDINGS			
OR that ned by ith and	EDICAL	5/A (R) h	emile	celany	- ×	een	1 □ YES 2		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
ECO puires this signed Health a		Caremon	an of 4	The E	wheth	~	- 14 Julius	(211 60.74	DF DEATH? 1 YES 2 NO			
AL RE ne law requ has been a Dept. of h	2	DID TOBACCO USE CONTR	RIBUTE TO CAUSE	OF DEATH Y	ES NO	☐ UNCERTAL	NE					
VITAL AN: The law tificate has b e State Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA								
PHYSICIAN: The this certificate his with the State Dirked, or Item	S	EXAMINER?	HOSPITAL:	doctions 3 DO4	OTHER:	10 m of C = 10 m						
	РНҮ	27. MANNER OF OEATH	28a. DATE OF INJURY			INJURY AT	26d. DESCRIBE HOW II	WILLIAM COOLINGS				
NG PHYS frer this cath with		1 Natural 5 Pending	(Month, Day, Year)		JURY	WORK?	200. DESCRIBE NOW I	NJOHT OCCURED				
ONG DING After death	BY	2 Accident Investigation	28e. PLACE OF INJUR	2V 44 ham - 4								
OR ATTENDING OR ATTENDING DIRECTOR: Atterhours after death item 28 is mail		3 Suicide 6 Could not be 4 Homicide detarmined	building, etc. (Sp	ecify)	street, tectory, c	HTICA	28f. LOCATION (Street a City or Town, State)	ind Number or Rural	Route Number,			
DIVISION OR ATTENE DIRECTOR: hours after litem 28 is	<u> </u>											
TAL OR / AL DIRE 72 hours 11 Item	립		CIAN: To the best of my kno									
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	COMPLET	one) 2 MEDICAL EXAMINE	R: On the baste of examinati	ion and/or investigation	on, in my opinio	n, death occured at the	time, data and placa, an	d due to the cause(s) and manner as stated.			
RTAI		296. SCHATURE AND TITLE OF CERTIFIER	1			29c. LICENSE NU	MBER	29d DATE SIGNE	D (Month, Day, Year)			
TO THE HOSPIT TO THE FUNERA be filed within 7 IMPORTANT: I	BE	In Goys	She	My				> 7/	195			
E E X E	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF C	DEATH (ITEM 27) (Type	Print)	D23066		1/4	/73			
		STANLEY BYSSHE	, M.D., 50	05 DUTCH	IMAN'S	LANE, E	EASTON, M	D 21601				
Ì						•						
	ł	JUL 06 1995	July d'avele	or Nardally								
	- 12	500	/1/									



Irene Smith

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO

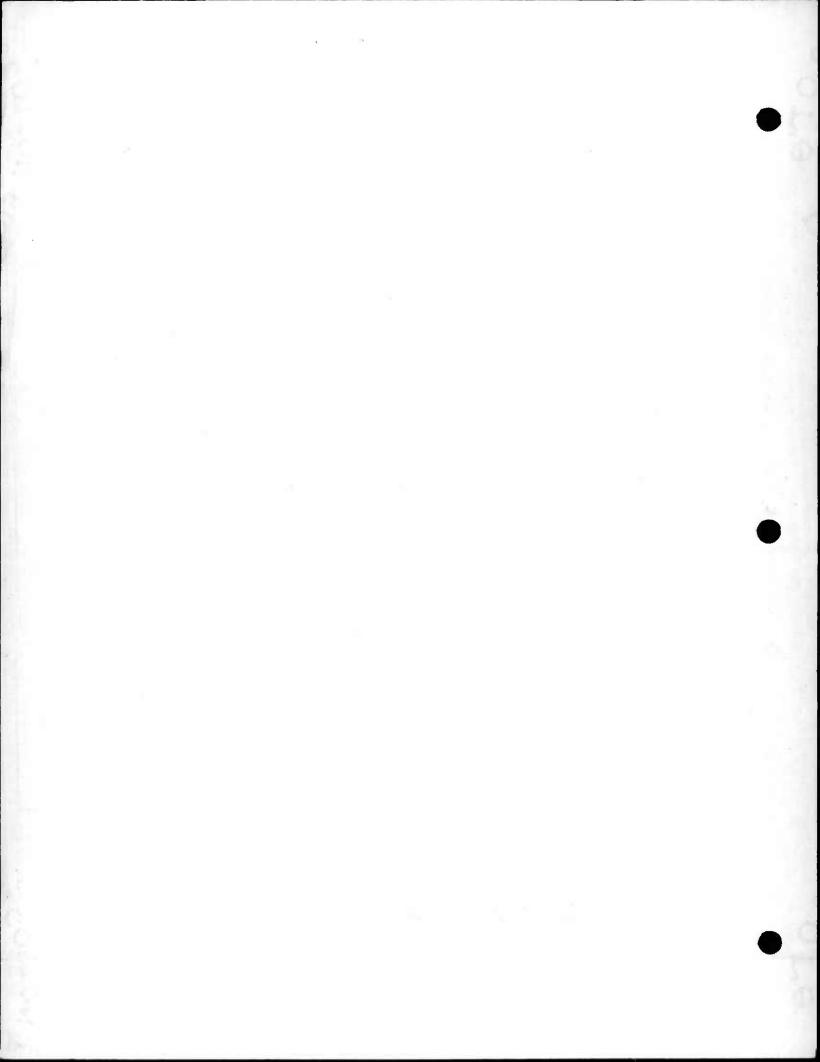
		REGISTRAR		CERTI	FICATE	OF DEAT	TH	R	EG. NO.					
	i	1. DECEDENT'S NAME (First, Middle, Last)					2.	DATE OF C	DEATH		YEAR	3. TIME OF D	EATH	
	- 1		IRENE F.	SMITH	ł –		-	Tulv	Q		95	3:25	7	,
	1 3	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. last birthday	/) IF UNDER 1	YEAR IF UNDER		DATE OF B	IRTH		6. BIRTH	IPLACE (State o	r Foreign	_
-		215-26-7260	1 🗆 M 2 💢 F	65 YRS	MONTHS	DAYS HOURS	MIN.	1/18		- 1	Countr	"		
3 should	DIRECTOR	9a. FACILITY NAME (If not institution, give :	street and number)		9b. CITY,	TOWN OR LOCATIO			7/29	9c. COUN		Cyland	1	-
2,		Salisbury Nursing	& Rehabilit	ation	Sal	isbury				Wico	mic	0		
SS .	EC	10a. STATE 10b. COUNT	Y	10c. C	SITY, TOWN OF	RICATION					\neg	10d. INSIDE C	urv.	_
permit, Pages 1,		Maryland Wic	comico				Hebro	n				LIMITS?		
	FUNERAL	10e. STREET AND NUMBER	D-11- 3			101. ZIP CODE				10g. CITIZ	EN OF V	WHAT COUNTRY	/?	
ian. transi	NE	11. MARITAL STATUS	Belle Aven				21830			United States				
020 physician, bunal-transit		1 Never Married 2 Married	FORCES? 1 YES	2 _NO	If.	yea, specify Cubar	n, Maxican, P	NIC ORIGIN? (Specify Yea or No— 14. RAC Blac Blac			14. RACE Black	E — American I k, Whita, atc.	ndlen,	
215-00 attending p	ETED BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES #	1	☐ YES 2 🙀 NO	Specify:				Speci	"y: Bla	ck	
or atter		15. DECEDENT'S EDU (Specify only highest grade		16a. DECEDENT	of work done du	CUPATION uring most of working	ng	18b. KIN	D OF BUSI	NESS/INDU	JSTRY			
D 2	F	Elementary/Secondary (0-12) 12th	College (1-4 or 5 +)	Labo	use retired.)			Pur	due	(Po	111 t	rv)		
E, MARYLAND 21215-0020 y be retained by the hospital or attending physic sage 5 should be detached for use as the burial be notified at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		1 Babo	1 01	16. MOTH	IER'S NAME					-17		_
		I	eonard S.	Johnso	n			s NAME (First, Middle, Meiden Surname) erine M. Peters Johns					n	
MAR retained to 5 should notified	TO BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILH	NG ADDRESS	(Street and Number						Omnoo	11	_
E, N y be ret sage 5 s		Jennifer P. J	ohnson	828	4 Ver	mont F	lace	, Ma	nass	sas,	VA	2211	1	
		20a, METHOD OF DISPOSITION 1yEk-Burlal 2 ☐ Cremation 3 ☐ Rem	eoval from State	D.PLACE AND DAT		ION (Name of		DATE	20c. LOC	ATION — C	Ify or To	wn, Stata		_
O 6 2 5		1 Donation 5 ☐ Other (Specify)		uantic	o Cen			-13	Qua	anti	co,	MD		
ALTIM death. Page funeral dire		21. SIGNATURE OF FUNERAL SERVICE LI	ZENSEE			AME AND ADDRES			T) = 7		D			
after after by the mova		Muhauf 7.	Caken		PC	amptom Box 4	l-Haw	kıns eder	-ESP	cow Sura	Fun M	eral D 216	Hom	le
		23. PART I. Enter the diseases, pr	complications that cause List only one cause on a	d tha death. Do	not anter t	ha moda of dyle	ng, such a	a cardiac	or reapire	etory arre	at,	Approx	lmata	_
M S S E		IMMEDIATE CAUSE (Final	List only ona cause on a	iach lina.								Onset a		
d within 24 ompletely fills. Cremation, the		disease or condition resulting in death)	· Pelme	el		or.						1370)	1	X
760 ad wit omple or cre even			DUE TO (OR AS A	CONSECUENCE	OF):							1		2
executed and con o bunial.	8	Sequantially list conditions,	b. 8116	CONSEQUENCE	000							42	-	
rau to the	RTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	1000	CONSCIDENCE	OF):									
e by by	윤	CAUSE (Disease or Injury that initiated events	c. DUE TO (OR AS /	A CONSEQUENCE	OFI:							310	7,	_
P.O. th certif	E	resulting in death) LAST	. 11/4	200	-							1	_	
	G											200	< .	
RDS, at the deal by the att and Menta y injury,	DICAL	PART II. Other algolificant condition	a contributing to death b	out not resulting	g in tha und	erlying cause g	lven in Par	t i, 24a.	WAS AN A		24b.	WERE AUTOPS		S
COR uires that signed by Health and	EDIC							. 1	YES 2 1	NO		OF DEATH?	F CAUSE	į.
- de ed	Σ											1 TYES 2	□ NO	
23 tas	Ä	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL					ERTAIN [
VITAL AN: The lav fificate has State Dep	SICIAN:	EXAMINER?	HOSPITAL:	26. PLACE OF DE	OTHER:	nly one)								_
F VIT	PHYS	27. MANNER OF DEATH	1 Inpatient 2 ER/Outp		-	ng Home 5 🗆 Ras								_
NG PHYSIC Ner this ce lath with th		1 Natural 5 Pending	(Month, Day, Year)	200. 1	NJURY M	BC. INJURY AT WORK?		d. DESCRIB	E HOW IN	JURY OCCI	JRED			
VOING After death	BY	2 Accident Investigation 3 Suicida a Could not be	28a. PLACE OF INJURY	— At home, farm	street factor			LOCATION	(Street an	d Number o	o Oumi E	loute Number,		_
S afer S	田	4 Homicida 8 Could not be datarminad	building, atc. (Spec	city)	, , , , , , , , , , , , , , , , , , , ,	,,		City or Tow	vn, State)	o reamber o	r nurar n	oute Number,		
H H H H	MPLET	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my know	ledge death occu	rrad at the tim	e data and place	and due to ti	ha anuncia)					_	_
PITAL ERAL In 72	N N		R: On the beals of examination) and manner a	a stated.	
FUN Within	8	29b. SIGNATURE AND THE OF CERTIFIE					NSE NUMBER							_
TO THE HOSPITAL OF TO THE FUNERAL D BE fled within 72 to IMPORTANT: If IN	B		Mel			0	7 6 7	18		MAIL T	7 /	(Month, Day, Yes		
F F 3 €	2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) /7/2	oe, Print)	100	- 1 3	7./		-	11	113		
		WILLIAM ROBINS, M.				T.TSRITOV	, MD							
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATUREO		TYPORT	, cm.							_
		1111 1 9 100	5 Jahr Davids	or Nartall	i i									



IDS, P.O. BOX 08/64	the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicial	y the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunjal-to Markel Husian price to be build be compared to the bunjal-to the bunjal
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FOR STATE REGISTRAR	STATE OF I	MARYLAND / DEPAR CERTIF		HEALTH AND F DEATH	MENTAL HYGIENE REG. NO.
1. DECEDENT'S NAME (First, Middle, Laist) Arnold S. Smith					2. DATE OF OEATH MONTH July 4, 19
4. SOCIAL SECURITY NUMBER 214-28-2899	5. SEX 123M 2 - F	6. AGE (In yrs. last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS		July 30, 1

		1. DECEDENT'S NAME (First, I								July 4, 1	995	YEAR	3. TIME OF DEATN 2:00 pm
_		4. SOCIAL SECURITY NUMBE 214-28-289		5. SEX 1XXM 2 F	6. AGE (In yrs. las		IF UNDER	VEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 30,		6. BIRTNE Country Mar	PLACE (State or Foreign
2, 3 should	OR	9a. FACILITY NAME (If not inst 3782 Main S	Street	et and number)			96. СПУ, Тгај		OR LOCATION OF D			ITY OF DE	
es +	DIRECTOR	RESIDENCE OF DECE 10a. STATE	10b. COUNTY			10c. CITY,	TOWN O	R LOCA	TION				10d. INSIDE CITY
.i. Pag		Maryland	Talbo	t		Tra	appe					6.51	LIMITS?
in. ansit perm	FUNERAL	3782 Main S						10	1. ZIP CODE 21673			_	HAT COUNTRY?
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should totilled at once.	ВУ	11. MARITAL STATUS 1 Never Married 2 X N 3 Wildowed 4 Divorce		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W		MED 10	11	yes, sp	CENDENT OF HISPA Hecify Cuban, Mexico 2 10 NO Special	NIC ORIGIN? (Specify Yean, Puerto Rican, etc.) fy:	s or No—	14. RACE Black, Specify	American Indian, White, atc. Black
215 attencise as	ED	15. DECEI (Specify only)	DENT'S EDUCA	TION propieted)	16a. DE	CEOENT'S U	SUAL OC	CUPATH	ON .	16b. KIND OF BU			
VD 21 ospital or ched for u	COMPLET	Elementary/Secondary (0-1	2)	College (1-4 or 5 +)	borer	-	инд то	osl of working	Factor Pop's			ıd
2 2 Z	BE CO	Joseph Bai	1ey						Annie	AME (First, Middle, Malden e Mae Smith	n		
41	10	196. INFORMANT'S NAME (Type/Print) Lula Mae Wongus 127 Goldsboro Street, Apt. 3, Easton, Md, 21601 20st, METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of Once of the Control of the											
AORI le 6 may rector, p		20st METNOD OF DISPOSITIO 1 Duriel 2 Cremation 4 Donation 5 Other (S	3 🗌 Remov	al from State	cemetery, cre		er pleca)				cation – c		
ALTIN death. Pag funeral di		21. SIGNATURE OF FUNERAL	SERVICE LICE	NSEE			22. N	AME A	NO ADDRESS OF FA	CILITY			•
BALT after death. by the funera moval.		John &	1. 3	ince	,			P.C	Box 16	h Funeral 87. Eastor	Md.	216	101
within 24 hours a spletely filled in by cremation, or remediate, the medic		23. PART. J. Enter the dis- shock, or hee IMMEDIATE CAUSE (Fina disease or condition resulting in death)	ert fallure. Li	mplications that st only one cau	se on each line			he mo	de of dying, aud	ch as cardiac or resp	Iratory arre	oet,	Approximate Interval Batween Onaet and Deeth
C 68°	CATION	disease or condition resulting in death) e											48yrs.
P.O. th certific ending pl I Hygiene or othe	CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):											
in the D	- 11	PART II. Other significant	conditions	contributing to	deeth but not r	esulting In	the und	erlyln	g causa given in	Part I. 24s. WAS AN			WERE AUTOPSY FINDINGS
ECO quires th n signed f Health	MEDICAL	Chroni	C Ob	struc	sue +	uln	ron	a	ryclis				AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	1	DID TOBACCO US		BUTE TO CA					UNCERTAI	N 🗆			
F VITAL F SICIAN: The law r certificate has be h the State Dept.	PHYSICIAN	25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 K NO		HOSPITAL:	VIDEO SET		OTHER						
SICIAN Certifi h the	H X	27. MANNER OF DEATH		26a. DATE OF	INJURY	28b. TIME	_		URY AT	6 Other (Specify) 28d. OESCRIBE HOW I	N.IURY OCC	HBEN	
O \(\xi \) \(\xi \) \(\xi \) \(\xi \)	ВУР	1 Netural 5 Pe	nding restigation	(Month, Da	sy, Year)	INJU	RY M		PRK? YES 2 NO				
ISIC TTENDI TOR: A after d		3 Suicide 6 Co	ould not be termined	28a. PLACE Of building, (F INJURY — At ho atc. (Specify)	me, farm, atr	eet, factor	y, offic	•	28f. LOCATION (Street a City or Town, State)	and Number	or Rural Ro	ute Number,
DIV SPITAL OR A INERAL DIREC Thin 72 hours	COMPLETED									to the cause(s) and mar time, data and place, an			and manner as stated.
TO THE HOSPITAL (TO THE FUNERAL D Be filed within 72 h IMPORTANT: It is	TO BE C	296. SIGNATURE AND TITLE O	011	ywoo	6	in	4		29c. LICENSE NUI D 468		29d. OATE	SIGNED (Month, Day, Year)
		J. Hollyto	ood, 1					Eas	ston, Md	. 21601			
Total Control	- 1	JULIU	עבבו	7									



95 23275

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Jennifer July Saboury 995 Ann 2256 6. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 5 SEX B. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH SEPT. 12, 1977 DAYS HOURS 1 M 2 XF 220-92-1024 17 MARYLAND YRS funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR BALTIMORE Shock Trauma Center Baltimore 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND **OUEEN ANNE'S** CENTREVILLE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 229 WHITE MARSH 21617 USA hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
 if yes, specify Cuban, Mexican, Puerto Rican, etc.)
 1 YES NO Specify: BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, etc. Never Merried 2 Merried B 3 Widowed 4 Divorced Specify: WHITE G 16a, DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEOENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Щ College (1-4 or 5+) Elementary/Secondary (0-12) COMPL 12 STUDENT 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at WILBERT H. SABOURY BARBARA ANNE STEELE 8 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 JOE SABOURY 229 WHITE MARSH, CENTREVILLE, MD 21617 pe 20a. METHOD OF DISPOSITION

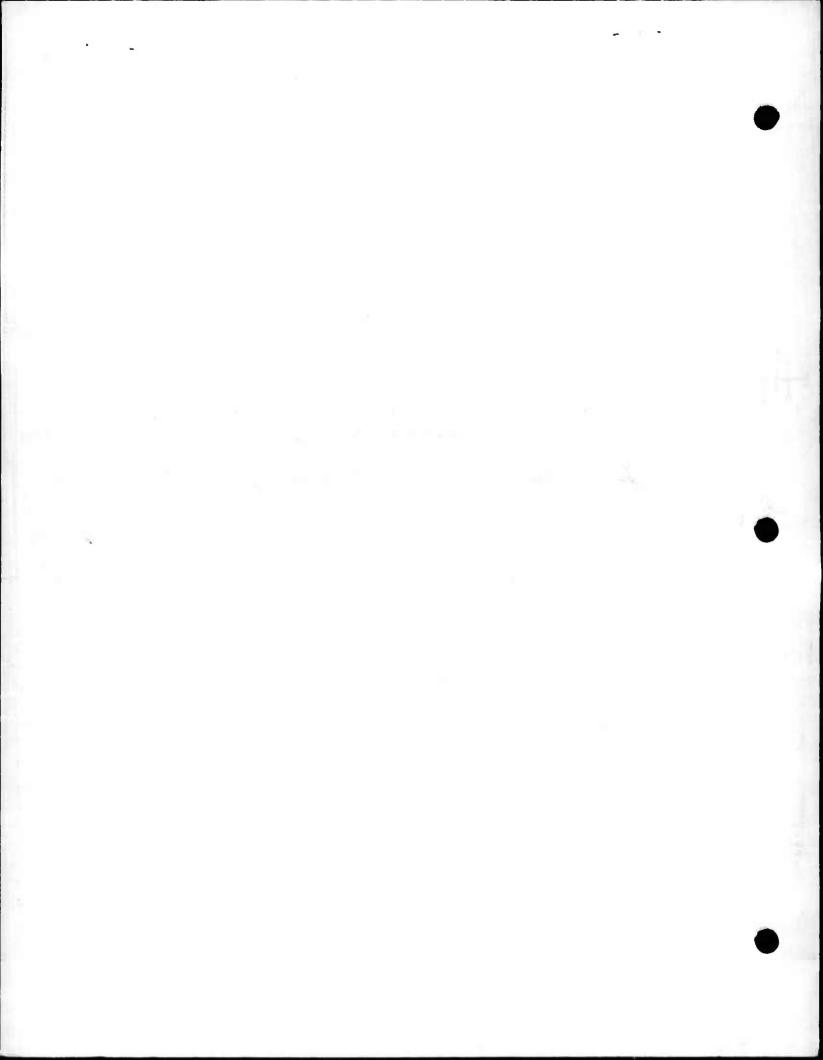
| State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | State | 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must CHESTERFIELD CEMETERY 7-19 CENTREVILLE, MD ехатіпет 21. SIGNATURE OF FUNERAL SERVICE LICENSEE NEWNAM FUNERAL HOME, P.A. NOHA R MERCERON S. HARRISON ST., EASTON, 200 filled in by the CFSP or removal medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fallure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Fine) Onaet and Death the cremation, disease or condition resulting in deeth) MULTIPLE attending physiclan and completely intelly intelly intelly intelligence prior to burial, crematic INJUKIES event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in deeth) LAST ö n signed by the atte PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY 1 WES 2 NO OF DEATH? 1 YES 2 NO t, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 has 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) OR ATTENOING PHYSICIAN; The certificate to the State EXAMINER? HOSPITAL: V 1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 6 28d. DESCRIBE HOW INJURY OCCURED IN PASSENGER OF AUTO INVOLVED IN COLLISION WITH TRUCK 27. MANNER OF DEATH 28e. DATE OF INJURY 7 (Month, Day, Year) 7 13 95 286. TIME OF 28c. INJURY AT this c marked, 1 Natural
2 Accident 5 Pending Investigation M 1 YES 2 NO В After t death 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Sulcide ETED. 59 8 Could not be 281. LOCATION (Street and Number or Rural Route Number City or Town, State) OIRECTOR: after 28 4 Homicide determined RT 301 & RT 304 CENTERVILLE MI hours COMPL 1 _ CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner as stated. TO THE FUNERAL OF THE FUNERAL OF THE FUNERAL OF THE WITHIN 72 HO IMPORTANT: It is 2X MEDICAL EXAMINER: On the emination end/or investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE C.M.E July 14 2 1995 COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

12. REGISTRAR'S SIGNATURE.

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The particular, many	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within at hours after death. Page 6 may be retained by	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.
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	1 - FOR STATE OF N	IARYLAND / DEPAR CERTIF	TMENT OF	HEALTH AND	MENTAL HYGIEN REG. NO	Ε	to your manage.			
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATN		3. TIME OF DEATN			
		Spicer			July 13,	1995	12:30 P M			
		6. AGE (In yrs. lest birthday) 86 YRS.	IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) Mar 27, 19	909	BIRTNPLACE (State or Foreign Country) Maryland			
"	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOW	N OR LOCATION OF DI	F DEATH 9c. COUNTY OF DEATH					
ECTOR	Dorchester General Hospit	al	C	ambridge	chester					
1 1 1 1 1	10a. STATE 10b. COUNTY			10d. INSIDE CITY						
AL DIR	Maryland Dorchester 100. STREET AND NUMBER	Ch	nurch C	reek	LIMITS? XX YES 2 NO					
FUNERAL	1841 Whitehaven Road			21622	US					
3		EVER IN U.S. ARMED	13. WAS D	ECENDENT OF NISPAN	. RACE — American Indian, Black, Whita, atc.					
₽	1 Never Married 2XX Married FORCES? X IF YES, GIVE WW WW	If yea,	If yea, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 NO Specify: Specify: Wh:							
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)									
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+) Sawmill Operator Lumber Industry									
8 0	17. FATHER'S NAME (First, Middle, Last)				ME (First, Middle, Maiden na Keene	Surname)				
B B	Lingan Travers Spicer									
	The card system of a second of the second				Poute Number, City or Tow					
e P	odenerine 1. Spicer F.O. Box 94 Church Creek, Maryland 2162.									
must	26a-METHOD OF DISPOSITION 143/Burlal 2 Cremation 3 Removal from State 4 Donation S Other (Specify)	Old Trinit			1		reek, Maryland			
횰	21. SIGNATURE OF JUNERAL SERVICE LIGENSEE	1020 2721120	22. NAME	AND ADDRESS OF FA	CILITY					
i examiner must be notified at once. TO BE COM	I for WI Romer						yland 21613			
or other traumatic event, the medical	23. PART (v Enter the diseases, or complications that shock, or heart failure. List only one ceus	ceused the death. Do note on each line.	ot enter the r	mode of dying, suc	h as cardiac or respi	ratory arrest	Approximate interval Between			
E	IMMEDIATE CAUSE (Final disease or condition									
H,	resulting in death)	y Mouther	enay				Minutes			
94	DUE TO (OR AS A CONSEQUENCE OF):									
r other traumatic	resulting in death) Due To (on as a consequence of): Due To (on as a consequence of): Sequentially list conditions, If any leading in immediate Due To (on as a consequence of): Years									
CAT	If any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury									
	that initiated events DUE TO (OR AS A CONSEQUENCE OF	7):							
CEH C	resulting in death) LAST									
≥I O	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WEF									
를 그	PART ii. Other significent conditions contributing to	leeth but not resulting in	n the underly	ing ceuse given in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS			
any injury.	PART II. Other significent conditions contributing to	leeth but not resulting i	n the underly	ing couse given in	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE			
	PART II. Other significent conditions contributing to a	leeth but not resulting in	n the underly	ing ceuse given in		MED?	AVAILABLE PRIOR TO CDMPLETION DF CAUSE DF DEATH?			
MEDIC	COPD, Congesti	re Near	a do	ulevo	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
23 shows any AN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAL 25. WAS CASE REFERRED TO MEDICAL	JSE OF DEATH YE	S NO	UNCERTAIN	PERFOR	MED?	AVAILABLE PRIOR TO CDMPLETION DF CAUSE DF DEATH?			
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PURIANT: If Item 28 is marked, or Item 23 shows any BE COMPLETED BY PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	JSE OF DEATH YE. 26. PLACE OF DEATH 27. PLACE OF DEATH 28. PLACE OF DEATH 28. PLACE OF DEATH 28. TIME INJURY — At home, farm, si tc. (Specify) Thy knowledge, death occurre- mination and/or investigation E OF DEATN (ITEM 27) (Type.	S NO H (Check only on OTHER: 4 Nursing H E OF URY M 1 Treet, factory, of d at the lime, du n, in my opinion	UNCERTAIN TO DOME 5 Residence NJURY AT NOME? YES 2 NO Titce V/ A ste and place, and due , death occurred at the	8 Other (Specify) 28d. DESCRIBE HOW II A 28f. LOCATION (Street as City or Town, State) to the cause(a) and man time, data and placa, an	MED? AUTHY OCCUR AUTHOR OF AUTHOR OF AUTH	AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO Fural Route Number,			
IPURIANI: II 16m 28 is marked, or 11em 23 shows any BE COMPLETED BY PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	JSE OF DEATH YE. 26. PLACE OF DEATH 27. PLACE OF DEATH 28. PLACE OF DEATH 28. PLACE OF DEATH 28. TIME INJURY — At home, farm, si tc. (Specify) Thy knowledge, death occurre- mination and/or investigation E OF DEATN (ITEM 27) (Type.	S NO H (Check only on OTHER: 4 Nursing H E OF URY M 1 Treet, factory, of d at the lime, du n, in my opinion	UNCERTAIN TO DOME 5 Residence NJURY AT NOME? YES 2 NO Titce V/ A ste and place, and due , death occurred at the	8 Other (Specify) 28d. DESCRIBE HOW II A 28f. LOCATION (Street as City or Town, State) to the cause(a) and man time, data and placa, an	MED? NJURY OCCUR Ind Number or to the color of the colo	AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO Pural Route Number, Buse(a) and manner as stated. GNED (Month, Day, Year)			



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30. NAME AND ADDRESS OF P

31. DATE FILED (MONTH, Day, Year)

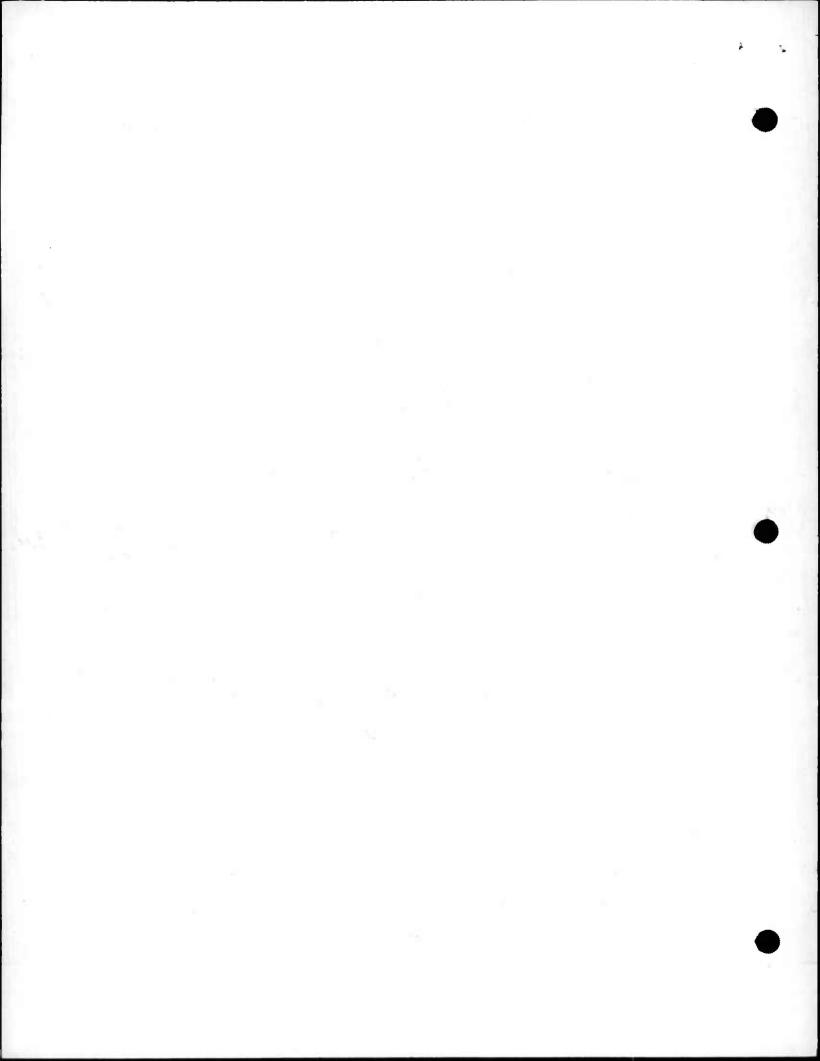
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	1 - STATE REGISTRAR	STATE OF MARYLA		IMENT OF H CATE OF		MENTAL HYGIEN REG. NO	_						
	1. DECEDENT'S NAME (First, Middle, Last) Clarence	□ Coaks				2. DATE OF DEATH	AY	3. TIME OF DEATH					
	4. SOCIAL SECURITY NUMBER		n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	07	16	75 09 45 AM					
	215-07-4831 9a. FACILITY NAME (If not institution, give str	1 💢 M 2 🗆 F 9	3 YRS.	MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) May 7,19	02	B. BIRTHPLACE (State or Foreign Country) Maryland					
TOR	West Nursing &				minster			Carroll					
DIRECTOR		Carroll	10c. CITY,	Hamps				10d. INSIDE CITY LIMITS? 1 YES 2 NO					
FUNERAL	100. STREET AND NUMBER 1302 Taylor Street 100. CIP CODE 21074 USA												
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 ☐ YES IF YES, GIVE WAR OR DA	2 X NO	13. WAS DECI	ENOENT OF HISPAN Helfy Cuban, Maxica 2 NO Specifi	NIC ORIGIN? (Specify Yes in, Puarto Rican, atc.) y:	or No- 1	4. RACE — American Indian, Black, While, atc. Specify: White					
COMPLETED	15. DECEDENT'S EOUC. (Specify only highest grade of Elementary/Secondary (0-12) 1 1	College (1-4 or 5+)	Hampstead Bank										
BE CON	17. FATHER'S NAME (First, Middle, Lest) William H. Seak	(S			Virgin	ME (First, Middle, Maiden nia Ingha	Sumame)						
10	19a. INFORMANT'S NAME (Typo/Print) Stewart Reed		3400	Halcyo	n Rd,	Route Number, City or Tow Stevenson	n, State, Zip C	21153					
	20a. METHOD OF DISPOSITION 1X Burlal 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val from State 20b.	PLACE AND DATE OF stery, cremetory or other CERMOUN	FDISPOSITION (Nar	terv			ty or Town, State					
	21. SIGNATURE OF BUNGRAL SERVICE LICE	W.Eli	ine	22, NAME AN	O ADDRESS OF FA	Eline	Fun	eral Home d, MD 21074					
	23. PART I. Enter the diseases, or co ahock, or heart fellure. L	omplications that caused list only one cause on ea	the deeth. Do no	ot enter the mod	de of dying, auc	h as cerdiec or respi	ratory arres	Approximete					
	iMMEDIATE CAUSE (Finel disease or condition resulting in death)	APTEX DUE TO (OR AS A	2165/L CONSEQUENCE OF)	EROT	OC CA	RPIUVA	SCVL	Onset and Death AR 15 VEA					
ATION.	Sequentially ilet conditions, if any, leeding to immediate cause. Enter UNDERLYING	if any, leeding to immediate											
CERTIFICATION	CAUSE (Disease or Injury that initiated eventa resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):	:									
الدا	PART II. Other eignificant conditione	contributing to death bu	t not reculting in	the underlying	ceuse given in	Pert i. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS					
MEDICA						PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
	DID TOBACCO USE CONTR	BUTE TO CAUSE OF	DEATH YES		UNCERTAIN	<u></u>		1 YES 2 NO					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH	(Check only one)									
YSI	1 TYES 2 NO	1 - Inpetient 2 - ER/Outpar	tient 3 DOA 4			6 Other (Specify)							
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJUI	RY WOR	IRY AT RK? ES 2 NO	28d. DESCRIBE HOW INJURY OCCURED							
COMPLETED	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY - building, atc. (Specif	- Al homa, ferm, atr	rast, fectory, office		281. LOCATION (Street a City or Town, State)	and Number or	Rural Route Number,					
IPLE		IAN: To the best of my knowle											
8	one) 2 MEDICAL EXAMINER:	On the basis of examination	and/or investigation,	, in my opinion, de	ath occured at the	time, data and pieca, en	d due to the	cause(a) and manner as stated.					
O BE	29b. SIGNATURE AND TITLE OF CERTIFIERY	Walle.	2 N.	10	29c. LICENSE NUM	496	29d. DATE S	SIGNEO (Month, Day, Year)					
IFI	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED CALISE OF DEAT	TH OTEN OF CO.	2-1-13									

OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

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	·	ansit permit. Pages 1, 2, 3 should		
LTIMORE, MARYLAND 21215-0020	ath. Page 6 may be retained by the hospital or attending physic	neral director, page 5 should be detached for use as the burial-	miner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within entiting relative feath. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

_		1 - STATE OF MARYL REGISTRAR	AND /	DEPART	MENT O	F HEALTH AND N	MENTAL HYGIEN				
Г		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
1		Sherlene May Singer					Jul 14		6:00 P m		
1		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. Isst birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 9. FACILITY NAME (If not institution, the street and number) 1. When the control of the street and number) 1. AGE (In yrs. Isst birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 1. A SOCIAL SECURITY NAME (If not institution, the street and number) 1. A SOCIAL SECURITY NAME (If not institution, the street and number)									
	œ	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 3704 Singer Street Hampstead Carroll									
	DIRECTOR	RESIDENCE OF DECEDENT									
	Ä	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LO				10d. INSIDE CITY LIMITS?		
		Maryland Carroll 100. STREET AND NUMBER			Hä	mpstead 10f. ZIP CODE		Ma CITIZEN	1 TYES 2 NO OF WHAT COUNTRY?		
	FUNERAL	3704 Singer Street				21074			JSA		
	BY FU	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR D	2X N	MED O	If yes	DECENDENT OF HISPAN, specify Cuban, Mexicer YES 2 X NO Specify	, Puarto Rican, etc.)	4	RACE — American Indian, Black, White, atc. Specify: White		
- 1		15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DEC	CEDENT'S L	SUAL OCCUP	ATION	16b. KIND OF BUS	SINESS/INDUSTR			
	COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)	(Gh lille.	Do NOT usa	retired.)	most of working	Ow	n Home	2		
nce.	MO	17. FATHER'S NAME (First, Middle, Last)		1104	30111		AE (First, Middle, Maiden				
ed at o	BE C	Edgar Merryman				Gladys	Dayhoff				
e notifi	2	19e. INFORMANT'S NAME (Type/Print) Roy Singer	3	704	Singe	er St, Ha	mpstead,	n, State, Zip Code MD 2	1074		
must b		20a. METHOD OF DISPOSITION 1	b. PLACE A	ND DATE OF	Crema	Name of ations		mpste	or Town, State		
iner		21. SIGNATURE OF THERAL SERVICE LICENSEE	1.		22. NAM	E AND ADDRESS OF FAC	Fline	Fune	ral Home		
ехаш		* XTeva W. El	n	e	934	S Main			, MD 21074		
or other traumatic event, the medical examiner must be notified at once.		23. PART 1. Enter the diseases, or complications that cause ehock, or heart failure. List only one cause on a IMMEDIATE CAUSE (Finel disease or condition resulting in death)	oech line.	py	www	mode of dying, such		ratory arrest,	Approximata interval Batwean Onset and Death		
rtic eve	Z	DUE TO (OR AS A	A CONSEQ	S A	tn	brust	A.		UNK,		
trauma	CERTIFICATION	Sequentially list conditione, if any, leeding to immediate cause. Enter UNDERLYING	A CONSEO	UENCE OF)							
other		CAUSE (Disease or injury that Initiated evente resulting in deeth) LAST	A CONSEO	UENCE OF)	:						
	- 11	d									
	8 P	PART II. Other eignificant conditions contributing to death b	out not re	euiting in	the underl	ying ceuse given in i	Part i. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO		
23 shows an	MEDIC						1 YE\$ 2	TONO	COMPLETION OF CAUSE DF DEATH? 1 ☐ YES 2 ☑ NO		
8	ااخ	DID TOBACCO, USE CONTRIBUTE TO CAUSE C	OF DEAT	TH YES	□ NO	UNCERTAIN					
item 2	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		T	Check only o	ne)					
ed, or i	2	1	patient 3		I ☐ Nursing	fome 5 D Residence (
marked, or		1 Maturel 5 Pending (Month, Day, Year)		A PAUL	7-1	WORK?	28d. DEŞCRIBE HOW II	NJURY OCCURE	D		
28 is		3 Suicide 6 Sould not be determined 29e. PLACE OF INJUM building, etc. (Soe	r — At hon city)	- Very st	for policy.	ffice	26f, LOCATION (Street a City or Town, State)	and Number or Ru	iral Route Number,		
IMPORTANT: If item	MP	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my know one) 2 MEDICAL EXAMINER: On the best of exemination							Z.1		
RTANT	u III	290. SIGNATURE AND TITLE DO CERTIFIED	A .		, in my opinio	29c. LICENSE NUM			NED (Month, Day, Year)		
iMP0	۱ ۵	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE	VM	1970 /5	Delmel	D335	99	7	-17-95.		
'		Dr. Philip Rusbarsky, Ai	rpor	rt Dr		te #24, N	Vestminst	ter, M	d •		
		31. DATE FILED (Month, Day, Year) JUL 1 8 1995 JUL 1 8 1995	ATURE	dall							

F) 55 19 •

	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-F4*hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEOENT'S NAME (First, Middle, Last) Stover 2. DATE OF OEATH 3. TIME OF DEATH MONTH Mildred Louise Stover 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 6/30/1912 5. SEX 6. AGE (In yrs. last birthday) IF UNDER I YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DAYS HOURS 214-82-8045 1 M 2 X F 83 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Carroll County General Hospita Westminster Carrol1 RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Carrol1 Westminster 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1452 Warehime Road 21158 United States 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMEO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-II yea, specify Cuban, Maxican, Puerto Rican, atc.) 1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Merried 2 Married ВУ 3 X Widowed 4 Divorced white COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 6 Homemaker n/a 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Theodore Franklin Miller BE Louise Annie Rodenhouse 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Shirley Bonner 1452 Warehime Rd., Westminster, MD 21158 Pe 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name 7/17/95 OATE 29c. LOCATION — City or Town, State Hust 1 M Buriel 2 Cremetion 3 L H 4 Donation 5 Other (Specify) Buriel 2 Cremetion 3 Removel from State Evergreen Memorial Gardens Finksburg, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel Katherene Pritts N wetter 412 Washington Rd., Westminster, medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, Approximata shock, or haart failure. List only one cause on each line. Intarval Between IMMEDIATE CAUSE (Finsi Onsat and Death the disease or condition resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 1 TYES 2 NO Shows 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{\overl ន 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) He H HOSPITAL: OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetlent 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28b. TIME OF INJURY 28d. OESCRIBE HOW INJURY OCCURED marked, 1 Netural 2 Accident 5 Pending М BY 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 50 0 Could not be COMPLETED 4 Homicide item 28 299 CENTIFIER

of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated,

LETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carroll Count

32. REGISTRAR'S SIGNATURE

Jalia Dhudson Realell

YOME.

31. DATE FILED (Month, Day, Year)

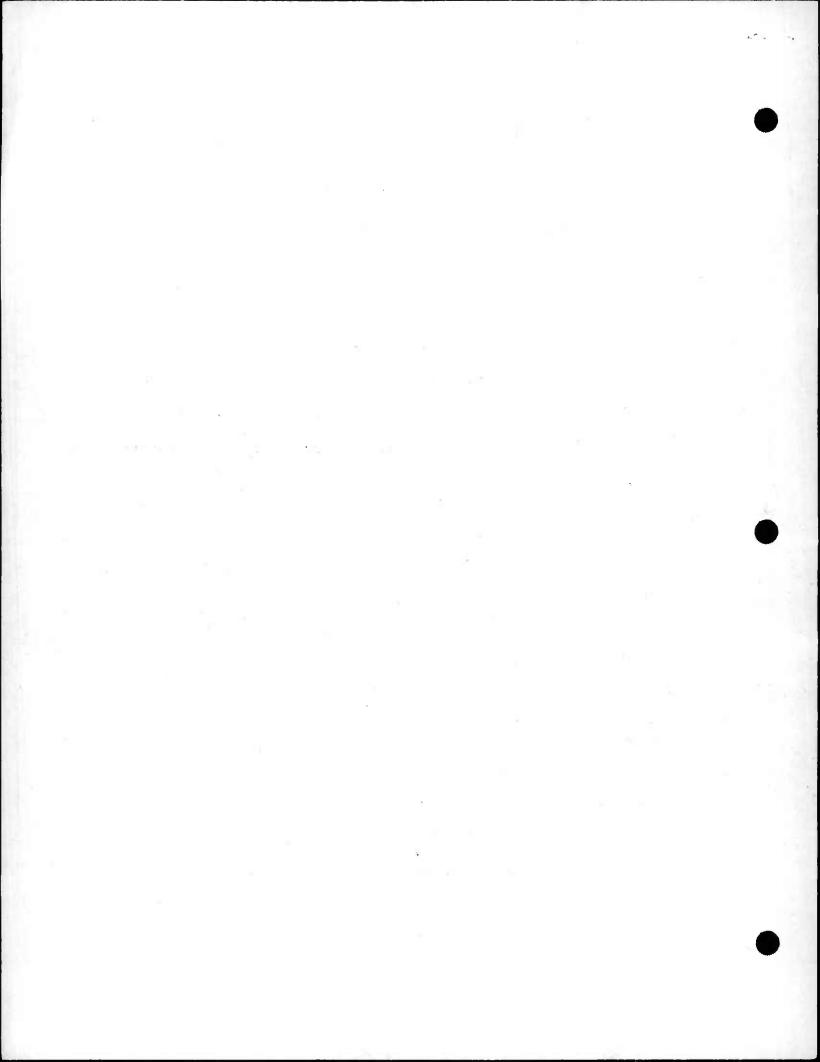
JUL18

29c. LICENSE NUMBER

atigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated,

OHMH-16 Ray 1/89

29d. DATE ŞIGNED (Morth, Day, Year)



DIVISION OF VITAL RECORDS, P.O. BOX 68760 S BALTIMORE, MARYLAND 21215-0020

30. NAME AND ADDRESS OF PERSON WHO CO

31. DATE FILED (Month, Day, Year)

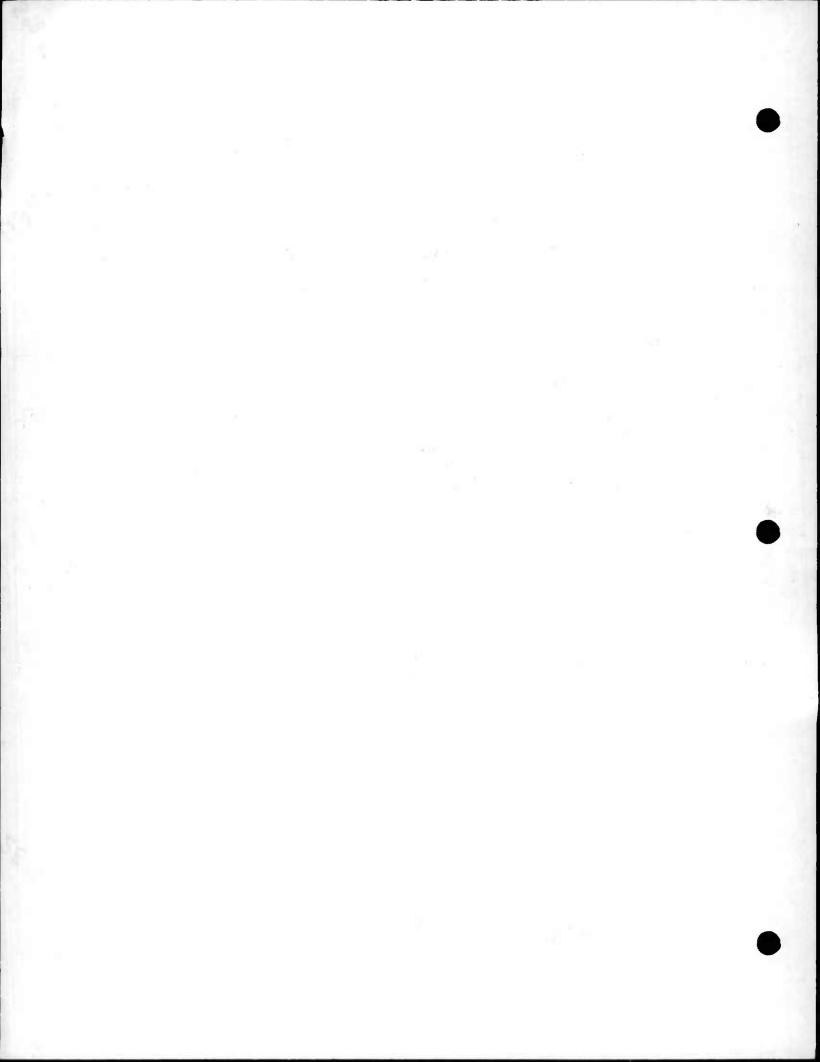
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	1 - FOR STATE REGISTRAR	STATE OF MA	RYLAN	D / DEPAR CERTIF	TMENT OF	HEALTH AND	MENT	AL HYGIEI			
	1. DECEDENT'S NAME (First, Middle, Las	0		OLITTI	TOATE O	DEATH		TE OF DEATH			3. TIME OF DEATH
	Betty	Т.			De	Llby	MON	TH	19	95	8:56A W
	4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yr	s. last birthday)	IF UNDER 1 YEA			E OF BUTH		8. BIRTHP Country)	LACE (State or Foreign
	230-34-2842 9a. FACILITY NAME (If not inetitution, giv	YRS.	Feb 10 1930 Marylan								
	Shady Grove A								9c. COUNTY OF DEATH		
DINECTOR	RESIDENCE OF DECEDENT		ROCKV	ckville Montgomery							
	Md Mor	ntgomery		_	Y, TOWN OR LO						10d. INSIDE CITY
	10e, STREET AND NUMBER			G	ermant						YES 2 NO
	19645 Crystal	Rock Dr.	Ap	t.22		20874				S.A.	IAT COUNTRY?
	11. MARITAL STATUS	12. WAS DECEDENT E			13. WAS I	DECENDENT OF HISE	ANIC ORIG	IN7 (Specify Ve			- American Indian,
	1 Never Married 2 Married	FORCES? 1 THE TENT OF THE TENT	YES 2	NO NO	If yes,	specify Cuban, Max	Ican, Puarte	o Rican, atc.)	a or no-	Black,	White, etc.
	3 Widowed 4 Divorced		1 □ YES 2 ™ NO Specify: Specify: Whit.						white		
	15. DECEDENT'S EI (Specify only highest gra	DUCATION de completed)	16a	Give kind of w	USUAL OCCUPY work done during as retired.)	ATION most of working	10	8b. KIND OF BU	ISINESS/INDU	JSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+)					Ì	E	1 0		
	17. FATHER'S NAME (First, Middle, Last)			walt	ress	- Daniel - Inches			l Serv	ice	
	Lester Perry					18. MOTHER'S					
ı	19a. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS (Stre	et and Number or Run		Hita		Code)	
i	Pov Salby									,	Md.20837
	20a, METROD OF DISPOSITION 1 Durial 2 Cremation 3 Re	2224	20b. PL/	ACE AND DATE	OF DISPOSITION				CATION — C		
	4 Donation 5 Other (Specify)			y, crematory or of nithsh			7/	17 Sm	ithal	hura	M a
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			22. NAME	AND ADDRESS OF	PACILITY			our y	, Md.
	Willi	C Kilt	-			ton Fun nesvill					
	23. PART I. Enter the diseases, o	complications that c	nused the	e deeth. Do n	ot enter the	mode of dying, at	ich as ca	rdiec or resp	olratory arre	st,	Approximata
1	shock, or heart failure IMMEDIATE CAUSE (Finel	s. List only one ceuse	on eech	line.	0						Interval Between Onset and Death
ı	disease or condition resulting in death)	Lone	u	5/	mere	2					17 11 xeeks
		Metastific Doninghi Conce. 2 Wee								- 11 -15	
	Sequentially list conditions,	b	2571	クし	poner	idhe	Con	au.			2 Weeks
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.											
	CAUSE (Disease or injury that initiated events	cDUE TO (Of	AS A COR	NSEQUENCE OF	7):						
	resulting in deeth) LAST	d									
	PART II. Other significent condition	one contributing to de	oth but m	at sacultina i	m Aba amalania		- 5				
	OASA	uchri fo	TUIN	deer	in the discerny	ing couse given i	n Part I.	PERFO	RMED?	A A	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE
		- /	-					1 TYES	NO	0	F DEATH?
	DID TOBACCO USE CON	TRIBUTE TO CAUS	SE OF D	FATH YE	SILNO	UNCERTA	IN D			1	TYES 2 NO
	25. WAS CASE REFERRED TO MEDICAL	THIS OF THE CAU			H (Check only or		III4 []		···		
	EXAMINER? 1 ☐ YES 2.□ NO	HOSPITAL:	3/Outpatien	H 3 DOA	OTHER:	ome 5 - Residence	8 D Ott	ner (Specify)			
l	27. MANNER OF DEATH	28s. DATE OF IN. (Month, Day,	URY	28b. TIM	E OF 28c.	NJURY AT		ESCRIBE HOW	INJURY OCCU	JRED	
i	1 Netural 5 Pending 2 Accident Investigation			11131		WORK? YES 2 NO					
	3 Suicide 8 Could not b 4 Homicide datarmined	28a. PLACE OF the building, atc	IJURY — A (Specify)	t home, farm, s	treat, tectory, of	fice	281. LO	CATION (Street y or Town, State	and Number o	r Rural Rou	ite Number,
		SICIAN: To the best of my									
COMPLEIED	2 MEDICAL EXAMI	NER: On the beals of axem	Ination and	f/or investigation	n, in my opinion	, death occured at ti	ne time, da	ts and place, as	nd dus to the	cause(a) a	ind manner as stated.
- 11	296. SIGNAPORE MYO TITLE OF CERTIF	ER A				29c. LICENSE N			29d. DATE	SIGNED (A	fonth, Day, Year)
200	TO HAVE AND ADDRESS OF THE PARTY OF THE PART	UTIL				3:7:	10		1	dy	16.95
- 11	30. NAME AND ADDRESS OF PERSON W	MU COMPLETED CALISE A	DE DEATH	(ITEM 27) /7	Print)				1/	71	

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TO BE COMPLETED BY FUNERAL DIRECTOR

ne hospital or attending phys	detached for use as the buni	once.
s after death. Page 6 may be retained by	n by the funeral director, page 5 should be removal.	dical examiner must be notified at
th certificate be executed within 24 hount	ending physician and completely filled in Hygiene prior to burial, cremation, or r	or other traumatic event, the me
iCIAN: The law requires that the deat	certificate has been signed by the attertie the State Dept. of Health and Mental	, or item 23 shows any injury,
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physicians.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bun be filed within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to bunial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BY PHYSICIAN: MEDICAL CERTIFICATION

BE COMPLETED

2

1 Natural 2 Accident

3 Suicide

													9!	5	2328	3
FOR STATE REGISTRAR		STATE OF I	MARYL	AND /	DEPAR	TMENT	0F H OF	IEALTH DEAT	AND I	MENT	AL HYGII					
1. DECEDENT'S NAME (First	, Middle, Last)				_					2. DA	TE OF DEATH		-		3. TIME OF I	FATH
	Howard	G1	enn	Wo	rthi	ngton	S	TRIN	E	MOI	NTH	DAY	199	5	1:00	Р. м
4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE	(In yrs. last	birthday)	IF UNDER 1		IF UNDER			TE OF BIRTH			8. BIRTI	IPLACE (Stete	or Foreign
214-10-1632		1 🔀 M 2 🗆 F	8	3	YRS.		DAYS	HOURS	MIN.	Mar	ch 9,		12		m Marylan	d
9e. FACILITY NAME (If not in	stitution, give s	treet end number)				9b. CITY, T				EATH		8	e. COU	NTY OF E	DEATH	
702 Maxwel	1 Aven	ue				F	rec	leric	k			\perp		Fred	lerick	
10e. STATE	10b. COUNTY	•				Y, TOWN OR									10d. INSIDE	CITY
Maryland	Fre	derick			F	reder	ick								LIMITS?	1000
10e. STREET AND NUMBER							101	. ZIP CODE				1	log. CITI	ZEN OF	WHAT COUNTR	Y7
702 Maxwe	11 Ave	nue							217	701				U.S.	A.	
11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER II	U.S. ARI	MED						GIN? (Specify to Rican, etc.)	Yee or	No-	14. RACI	E — Americen k, White, etc.	ndlen,
1 Never Married 2 X 3 Wildowed 4 Divo	rced	IF YES, GIVE V			•			2 ₹ NO	Specify		o Mican, etc.)			Spec		ite
15. DEC (Specify only	EDENT'S EDU	CATION completed)		(Gh	ve kind of v	USUAL OCC	UPATIO	ON st of workin	0	1	6b. KIND OF I	BUSINE	ESS/IND	USTRY		
Elementary/Secondary (0	-12)	College (1-4 or 5	+)	life.	Do NOT us	Die					Tool	an	d D	ie		
17. FATHER'S NAME (First, M	iddle, Last)				-			18, MOTH	IER'S NA	ME (First	t, Middle, Malo	len Sur	neme)			
Howard Victor	or Str	ine									Rice		,			
19e. INFORMANT'S NAME (7	ype/Print)	-		19b	MAILING	ADDRESS (S	Street e	nd Number	or Rural F	Route Nu	mber, City or 7	lown, S	State, Zip	Code)		
Mrs. Bessie		Strine		7	02 M	axwel	1 A	ve.,	Fre	eder	ick, l	Md.	21	701		
20e. METHOD OF DISPOSITI 1 Deniation De	n 3 🗆 Reme	oval from State	cam	etery, cren	natory or ot	proispositi ther place)			Tv	1		100AT			wn, State	Mel
21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE		UIII.	ULIV			ID ADDRES			13) 1	995	_ F	rede	rick,	Ma.
- Xieler	R.C.	C. Bus	ford	_MOO	021			-			rd Fu					
23. PART i. Enter the di	seases, Dr C	complications that	t caused	the dea		Dt enter th	e mo	de of dyi	Chur ng, suci	h as ce	St.	Pre	ory arr	ick.	Approx	1.701 imate
immediate cause (Fin		List only one cau	se Dn e	ach ilna.									-			Between
disease or condition resulting in death)	→	e ve z	-7 50	4		***	سر در د	T-1			06.4	10m -1	- /			
		DUE TO	(OR AS A	CONSEQ	UENCE OF	7:				7			7 /			
Sequentielly list conditi	one T	b				2000	ク									
if any, leeding to immed	liete	DUE TO	(OR AS A	CONSEC	UENCE OF):										
cause. Enter UNDERLYI																
that initiated events resulting in deeth) LAS	· •	DUE TO	(DR AS A	CONSEC	UENCE OF):										_
															Ī	

PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i.

24a. WAS AN AUTOPSY PERFORMED?

24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO

1 TYES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: 1 TYES 2 NO 27. MANNER OF DEATH

1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF

OTHER:
4 | Nursing Home Residence 6 | Other (Specify) 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED

1 YES 2 NO 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only	1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated.
one)	2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) and menner se stated

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D14626

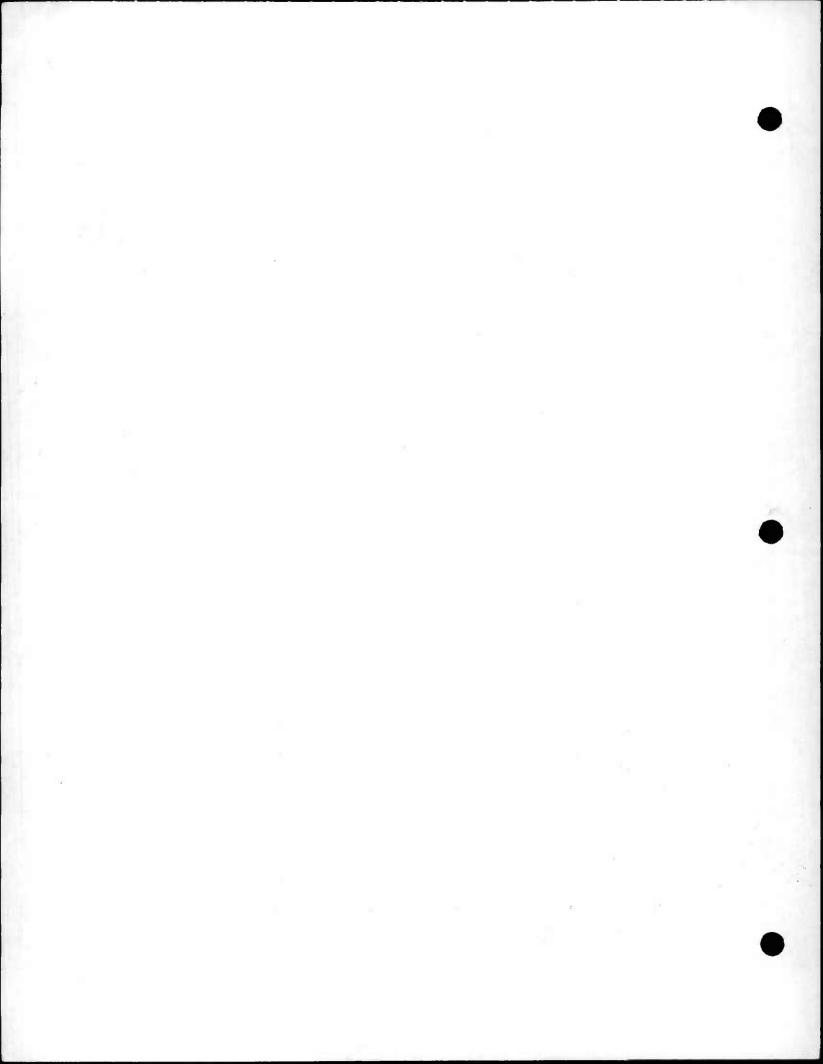
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

P. Gregory
31. DATE FILED (Month, Day, Year) Gregory Rausch, M.D., 501 West Seventh Street, Frederick, Md. 21701

19 JUL

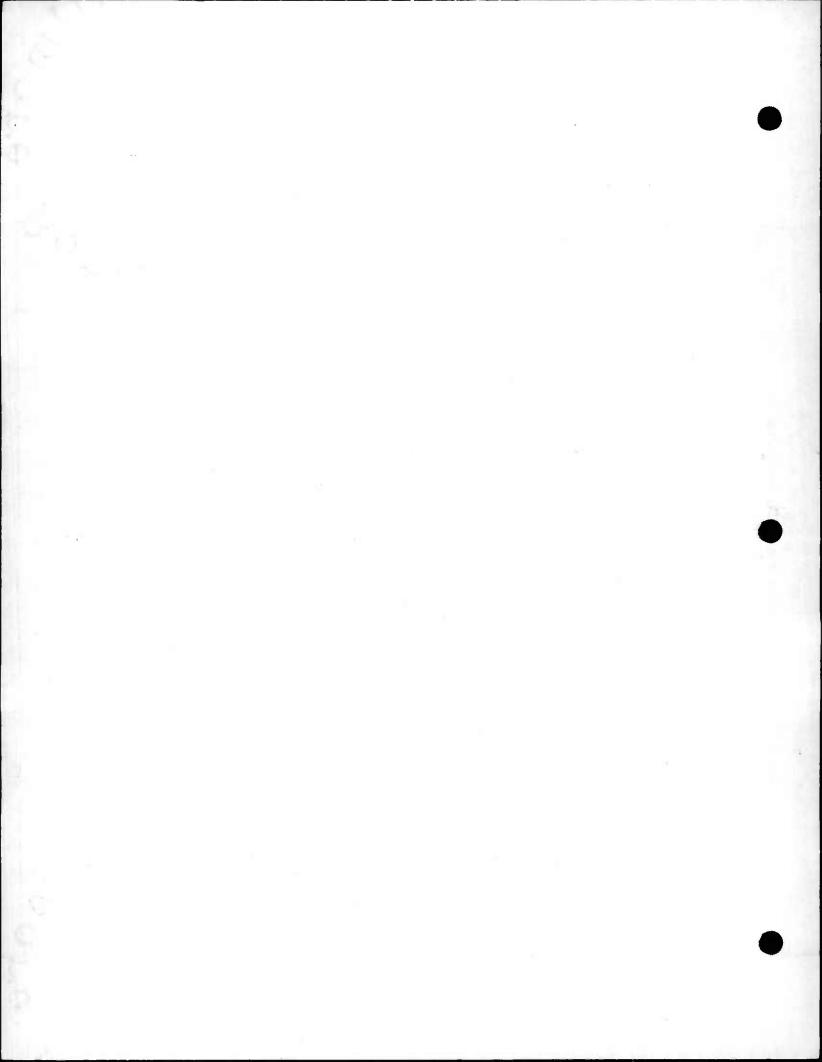
Investigation

32. REGISTRAR'S SIGNATURE



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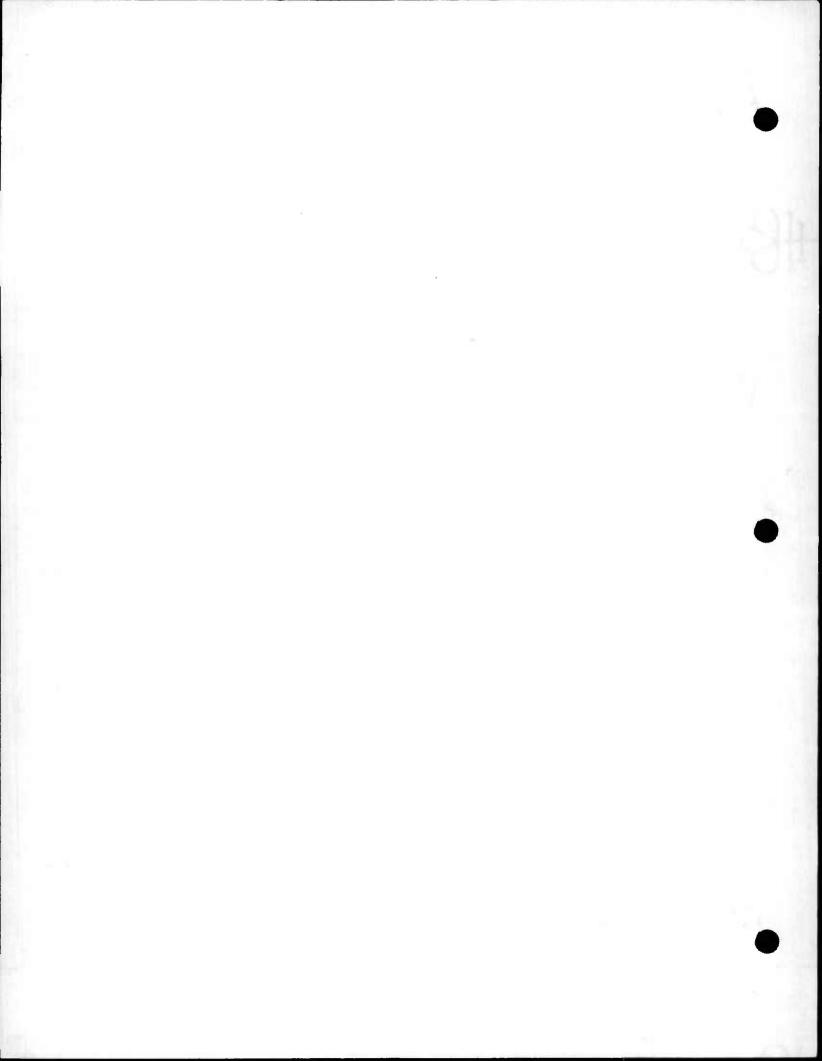
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	CIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. leat birtho	MONTHS DAVE	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)
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	rederick Memor	<u>ial Hos</u> pit	tal	Frede	rick		Fre	ederick
RESI	TATE 10b. COU	NTV	100	CITY, TOWN OR LOC	471011			
Ма		ltimore		Middle R				10d. INSIDE CITY LIMITS?
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3 🔯 w	Widowed 4 Divorced	IF YES, GIVE W	WAR OR DATES	1 🗆 YE	S 2 NO Specify	r:	1	Specify: White
Eler 17. FATI	15. DECEDENT'S E	DUCATION	16a. DECEDER	NT'S USUAL OCCUPAT	TION	18b. KIND OF BU	ISINESS/IND	USTRY
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	3 years	ounder first or or		artment M	anager	Aircra	aft Bu	uilding Compan
17. FAT	THER'S NAME (First, Middle, Last)					ME (First, Middle, Maider		
	ıdley Strasber	ger				t Fleischr		
10a JNI	FORMANT'S NAME (Type/Print)	0	19b. MAII	LING ADDRESS (Street		Route Number, City or Tox		Codel
Ge	eorge R. Stras	herger						Heights MD 21
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1 XBu	uriel 2 Cremetion 3 Reconstion 5 Other (Specify)	emoval from State	cemetery, crematory	Memorial	Gardene			City or Town, State r, Maryland
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1	Wests	()	200					AL HOMES, P.A.
23. PA	ADV I Enter the discourse			11201	NURTH MAK	KET ST. F	REDER	ICK, MD 21701
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FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY William YEAR Earl Smith -BABY BOY SCOTT JULY 14, 1995 7:05 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State of Foreign 1 🗆 📈 2 🗆 F 1995 July 13, Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 X YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 101. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 1622 North Freedom Way 21212 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 📉 Never Married 2 🗌 Married BY 3 Widowed 4 Divorced Black COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done life. Do NOT use retired.) ast of working Elementary/Secondary (0-12) College (1-4 or 5 +) ONCE. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Richard Smith Ħ Jacquetta Scott 8年 notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jacquetta Scott 1622 North Freedom Way, Baltimore, Maryland 21212 e 20a. METHOD OF DISPOSITION
1 Burlel 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Learnetery cremetory or other place)
The Johns Hopkins Hospital 7/14/95 Baltimore, Maryland 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY The Johns Hopkins Hospital 600 North Wolfe Street, Baltimore, Maryland n by the f removal. medical 23. PART i. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ehock, or heart feliure. List only one ceuse on each line. filled in by Approximate 0 Interval Between **IMMEDIATE CAUSE (Fine)** Onset and Death and completely fille burial, cremation, the disease or condition_ Pulmonary Henry Pour to (OR AS ACONSEQUENCE OF): Henrychale 5 hxs event, 1 reaulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 Innaturity other traumatic CERTIFICATION Extreme 30hrs Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 if any, leading to immediate cause. Enter UNDERLYING attending physician ental Hygiene prior to 2 CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events recuiting in deeth) LAST injury, PART ii. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any Atracranial mass 1 X YES 2 | NO Shows 1 TES 2 NO been x. of t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{\overline{\text{N}}}\) UNCERTAIN \(\Boxed{1}\) Dept. PHYSICIAN: OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate h HOSPITAL: OTHER:
4 \(\text{Nursing Home} \) 5 \(\text{Rasidenca} \) 8 \(\text{Other} \) (Specify) 1 TYES 2 NO 1 Unpetient 2 ER/Outpetient 3 DOA 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED this c marked, (Month, Day, Year) 1 Natural 1 YES 2 NO BY After death 2 Accident Investigation DIRECTOR: Af hours after de item 28 is r 3 Suicide 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 🔲 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE DE filed within 72 hours at IMPORTANT: If item 2: 29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(s) and manner as stated. beels of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTI 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month. Day, Year) D45991 > JULY 14, 1995 9 VHD OOMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MODRESS OF PERSON 600 N. Wolfe Sr., Baltinone, MD 21287 McCure Jusan K. M.D. 19952. REGISTRATES STRATURE REALLY

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



Trances MABEL Stonestreet July 17, 1995 8:3		FOR STATE REGISTRAR	STATE OF MARYLAN	ND / DEPARTME CERTIFICAT			MENTAL HYGIEN					
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WILLIAM W. JENKINS Type: Informant's NAME (Type/Print)		(Specify only highest grade of Elementary/Secondary (0-12)	Completed) College (1-4 or 5 +)	(Give kind of work don life. Do NOT use retired	e during most of .)	working			SINESS/INDUSTRY			
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ARK G. BROHAM MO0053 23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiratory arrest, into the disease or condition resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDER/ING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (1	1 P Burtal 2 Commation 3 Pamo	206.Pl	LACE AND DATE OF DISP	SITION (Name of	t	DATE 20c. LO	CATION - CI	ity or Town,	, Stata		
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That initiated events resulting in death) LAST OUE TO (OR AS A CONSEQUENCE OF): d		23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fallure. List only one cause on each line. iMMEDIATE CAUSE (Final disease or condition resulting in deeth) e. Atherosclerotic Cardiovasc Desease									mata Between ind Death	
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2 Accident 3 Suicide 6 Could not be detarmined 26a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 26a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)		1 Netural 5 Pending		28b. TIME OF INJURY M	WORK?							
29a. CERTIFIER (Check only Description on the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. Description on the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner.		3 Suicide 6 Could not be	26s. PLACE OF INJURY — building, atc. (Specify)	At home, farm, street, fo			261. LOCATION (Street a City or Town, State)	and Number of	Rural Route	9 Number,		
	OMPLE	(Check only								nd manner as	stated.	
296. SIGNATURE AND TO CE CENTRED MOUNTED DE LE 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED MOUNT, DON 297. 17/	BE	296. SIGNATURE AND TO SECURE	1	· mt		LICENSE NUM	BER				,	

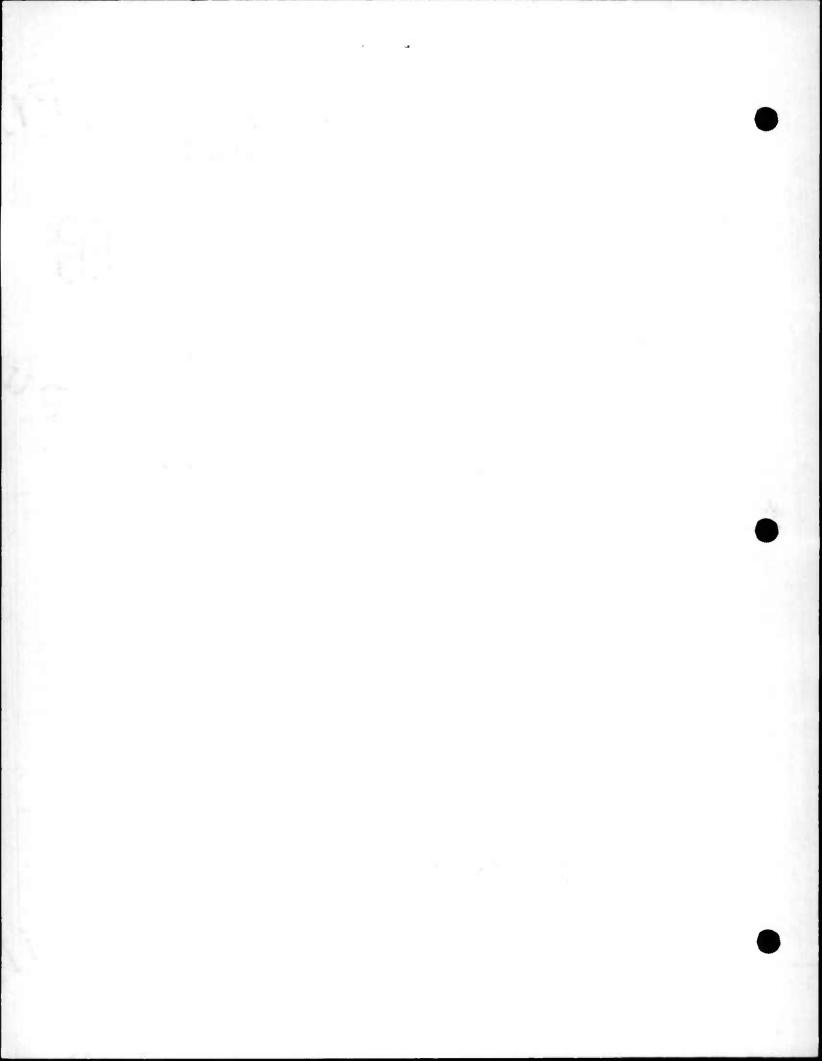
Charlene Letchford, M.D.

31. OATE FILED (Month, Day, Year)

32. REGISTRAR'S SIGNATURE

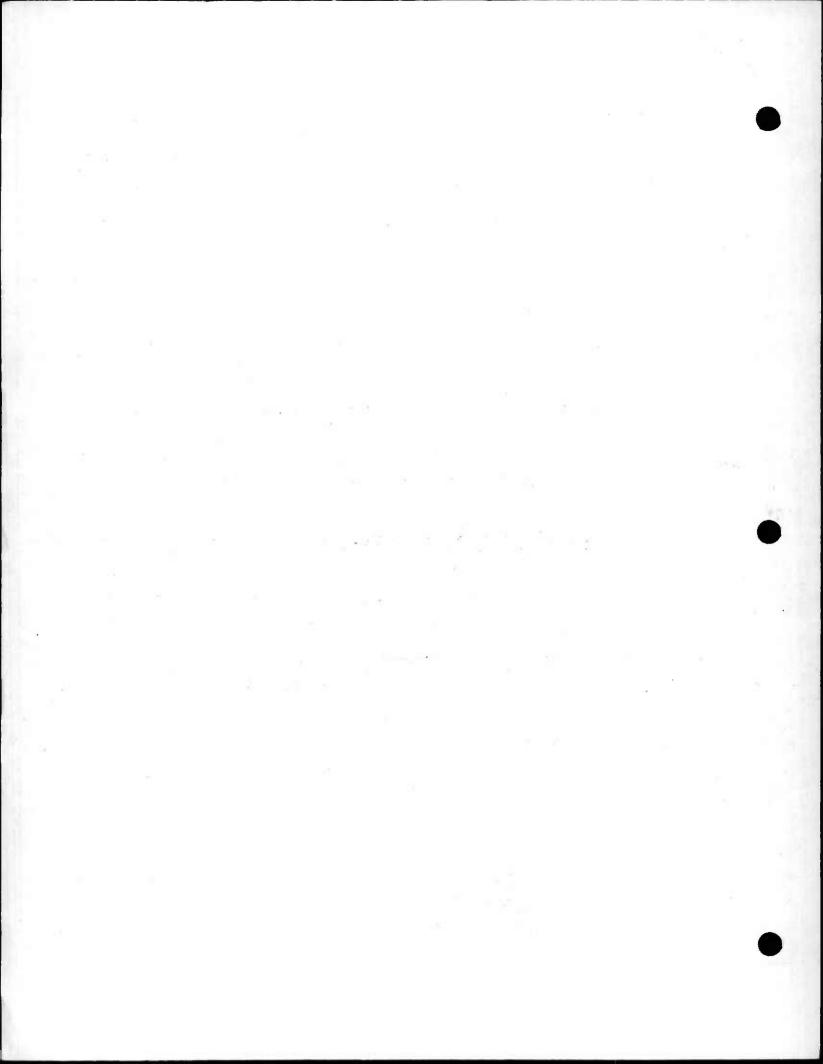
Julia Davidson Rardall

Waldorf, Maryland 20602



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

1		REGISTRAR		CERTIF	FICATE OF	DEATH	REG. NO).		
		1. DECEDENT'S NAME (First, Middle, Last) Eugene Paige SHUI	DD				2. DATE OF OEATN MONTH	AY YEAR	3. TIME OF OEATN	
					···	,	7 1	8 95	12:34 TM	
s 1, 2, 3 should		4. SOCIAL SECURITY NUMBER 215-18-2178	1X M 2 □ F 7	(In yrs. lest birthday)	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug. 5, 191	Countr	PLACE (State or Foreign ry) ryland	
		9a. FACILITY NAME (If not institution, give a			9b. CITY, TOWN	OR LOCATION OF D		9c. COUNTY OF D		
	DIRECTOR	Washington Cour	ity Hospital		В	lagerstow	m	Washir	igton	
ages	R	10a. STATE 10b. COUNTY			TY, TOWH OR LOCA				10d. INSIDE CITY LIMITS?	
Tit. P	16		ington	H	agerstow	m			1 X YES 2 NO	
n. ansit peri	FUNERAL	837 Noland Drive			10	01. ZIP COOE 21740	ı	10g, CITIZEN OF W	VHAT COUNTRY?	
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should notified at once.	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Nidowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 X YES IF YES, GIVE WAR OR I W. W. II	S 2 NO	13. WAS OECENDENT OF NISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			e or No— 14. RACE Black Speci Whi		
215 attend		15. DECEDENT'S EDU	CATION	16a. DECEDENT'S	S USUAL OCCUPAT	ION	16b. KIND OF BU	SINESS/INDUSTRY	LE	
212 al or al for us	COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u	work done during m	ost of working				
ND nospiti	MPL	9	0	crane o	prtruc	k driver	rai	1road		
LAN the hose detach		17. FATHER'S NAME (First, Middle, Last)			-		AME (First, Middle, Meiden	Sumame)		
RYL ned by t	88	Clayton C. Shupp 19a, INFORMANT'S NAME (Type/Print)					Mowen			
	2	Jeanette L. Shupp)				Route Number, City or Tow erstown, M.		21740	
		20a. METHOD OF DISPOSITION	20	0b. PLACE AND DATE	OF DISPOSITION /N	leme of		CATION — City or To		
ALTIMORE, leath. Page 6 may be funeral director, page		1XX Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State Co.	Rest Ha	ven Ceme	tery 7	The state of the s		, Maryland	
ALTIN death. Pag e funeral dii al.		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	- /	22. NAME A	ND ADORESS OF EA	ACILITY		·,,	
0 = 0		MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740								
B B by the or removal		23. PART I. Enter the diseases, or o	complications that cause	ed the death. Do	not entar the me	oda of dying, suc	ch as cardiac or reapi	fratory arrest,	Approximate	
		IMMEDIATE CAUSE (Final	List only one cause on	each line.	-	+	0	\cap	Interval Between Onset and Death	
within 73 petely fill cremation.		resulting in death)	bra.	عاصه	2000	de	- H-	Ilma	m 25m	
68760 ecuted with and complete burial, crem attic event.			O DUE TO JOR AS	A CONSEQUENCE O	()()	-	0/7	7), 1		
	o N	Sequentially list conditions,	DUE TO (OR AS	A CONSEQUENCE O	A V	ens	strict.	though	شحن	
BOX ante be e hysician i prior to	CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	itel.	2	Bal	7 (Liller	La !	1	
o ph	F	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	A CONSEQUENCE O	P):	1	30000	0	45	
P. Car Hy	HH.	resulting in death) LAST	d			V				
DS, the dear d Menta infury,		PART II. Other significant condition	s contributing to death i	but not regulting	in the underlyin	g cause given in	Part I. 24s. WAS AN		WERE AUTOPSY FINDINGS	
CORD res that the spend by th seatth and N ns any inti-	EDICAL	Proto rel	is De	w	Jue	per	PERFOR	/	MAILABLE PRIOR TO COMPLETION OF CAUSE	
O 5 42 E1	ME	rober	V			- 1	V		OF SEATH!	
AL RE Fred Fred Fred Dept. of 123 sho		DID TOBACCO USE CONTI	RIBUTE TO CAUSE O		demonstrate Contraction in commercial in		иВ		~	
户 产 # # B	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	OTHER:	72-2-5	_			
11 2 五年	PHYS	T YES 2 NO 27. MANNER OF DEATH	1 ☐ inpetient 2 ☐ ER/Out 28s. DATE OF INJUSTY		4 - Nursing Hon	ne 5 🗆 Residence	6 Other (Specify)			
O美世里		1 Netural 5 Pending	(Month, Day, Year)		JURY WO	ORK7 YES 2 NO	28d. DESCRIBE HOW II	NUMY OCCURED		
ATTENDING STORY After death 28 is man	BÁ	2 Accident Investigation 3 Suicide 6 Could not be	28s. PLACE OF INJUN	Y At home, ferm,			281. LOCATION (Street a	and Number or Flural R	custo Numbries	
DIVISION OR ATTENDING P DIRECTOR: After of them them 28 is mark		4 Homicide determined	building, etc. (Spe	saly)		201	City or Town, State)	ili		
DIV L OR A Z bours Z bours	COMPLET	29s. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my know	wledge, death occurr	red at the time, date	and place, and dur	to the cause(s) and mar	mer sa stated.		
HOSPITAL FLAKERAL WITHIN 72	O.		R: On the basis of examination						and manner as stated.	
THE HOSP THE FUNET Fleet within	E	SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI		294-DATE SIGNED	(Month, Dec Year)	
E E E E	\$1	1 CAA	en			D1243	36	> +1X	90	
	-	TO HAME AND ADDRESS OF PERSON WHO	COMBLETED CAUSE OF DE	EATH (ITEM 27) (Type	, Print)					
	1	SC DATE FILED (ASSOCIAL DIN. YOUR)	AD REGISTRAR ASIGN	- J						
_		JUL 2 1995 Jul	A SAUCISCO ACAD	all						



3. TIME OF DEATH

47

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 X YES 2 | NO

white

Approximate

Interval Between

Onset and Death

mont

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH?

1 - YES 2 - NO

29d. DATE SIGNED (Month, Day, Year)

. 19.95

21740

8. BIRTHPLACE (State or Foreign

9c. COUNTY OF DEATH

U.S.A.

washington

10g, CITIZEN OF WHAT COUNTRY?

Purcel1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

29c. LICENSE NUMBER

14/66

FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH ALLY-Jack (none) Summers 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. DATE OF BIRTH (Month, Day, Year 186-28-6744 1 🔀 M 2 🗆 F 59 DAVE HOURS 9e. FACILITY NAME (If not Institution, give street end number) 96. CITY, TOWN OR LOCATION OF DEATH Washington County Hospital DIRECTOR Hagerstown Pages 1, 2, RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Pa. Fulton Waterfall permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE P.oBox 43 use as the burial-transit 16689 hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yee, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS **BALTIMORE, MARYLAND 21215-0020** 1 Never Merried 2- Merried IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced 1958-1960 COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY nentary/Secondery (0-12) College (1-4 or 5+) Driver Transportation once. 17. FATHER'S NAME (First, Middle, Last) George W. 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Summers 7 BE Rosa notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary K. Summers P.O.Box 43 Waterfall, Pa. 16689 Pe 20 METHOD OF DISPOSITION
1 M Burlat 2 C Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must cometery, cromatory or other place) HustontownCemetery Donation 6 - Other (Specify) _ 31 Hustontown, 21. SIGNATURE OF FUNETIAL SERVICE LICENSEE medical examiner 22. NAME AND ADDRESS OF FACILITY Burner Trade Services 1037 Dual P1. .Hagerstown.Md. completely filled in by the rial, cremation, or removal, 23. PART I. Enter the diseases, or complicatione that ceused the deeth. Do not enter the mode of dying, such as cardiec or reapiratory arrest, ehock, or heert failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final other traumatic event, the disease or condition DUE TO (OR AS A CONSEQUENCE OF): Merinsitis reaulting in death) HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with DIVISION OF VITAL RECORDS, P.O. BOX 68769 Hygiene prior to burial, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION and Sequentially liet conditions, If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events signed by the attending Health and Mental Hygiei resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceues given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 23 shows any (rypto coccal 1 TYES 2 THO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DINCERTAIN PHYSICIAN: Dept. certificate has b 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO 1 Inpetient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) the 27. MANNER OF DEATH 28e. DATE OF INJURY this c marked, 26b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural DIRECTOR: After the hours after death volume 18 is mark 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, atreet, tectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER
(Check only one)

1 DEERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner se stated.) THE HOSPITAL () THE FUNERAL D : filed within 72 h TO THE HOSPITAL OF THE FUNERAL D DE filed within 72 ho 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) end menner ee stated.

Melaward

32. REGISTRA'S SIGNATURE

1799

Howell

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

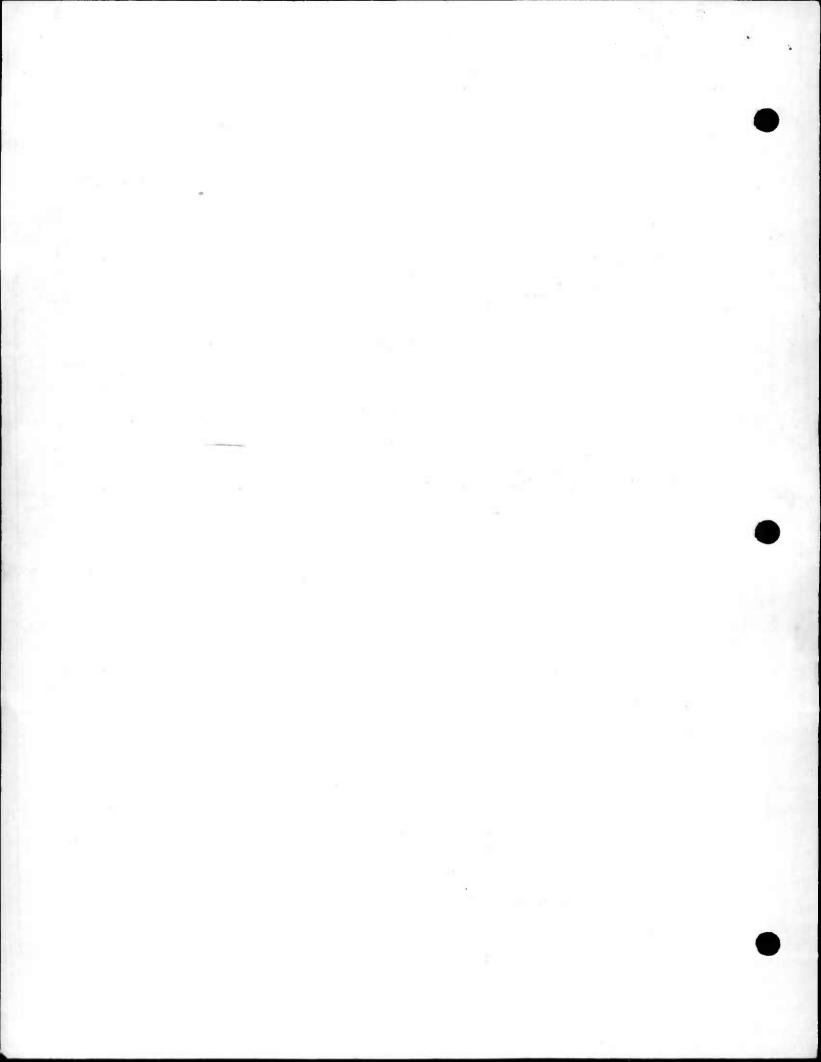
McCo

29b. SIGNATURE AND TITLE OF CERTIFIER

JUL 2 1 1995

BE

2



30. NAME AND ADDRESS OF PERS

MAH HA

31. DATE FILED (North, Day, Year)

JUL 2 5 1995

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

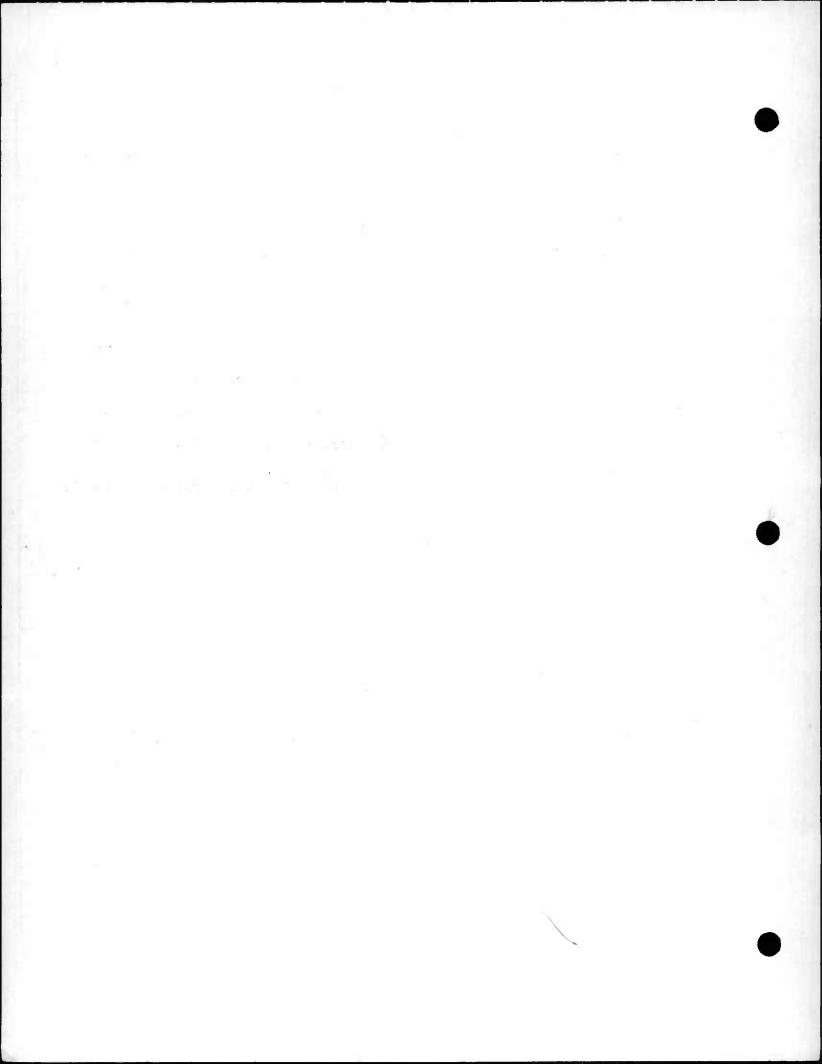
H. F. G. C. M. I)

L. 22. REDISTRAR'S SIGNATURE

Alia Division Roulel

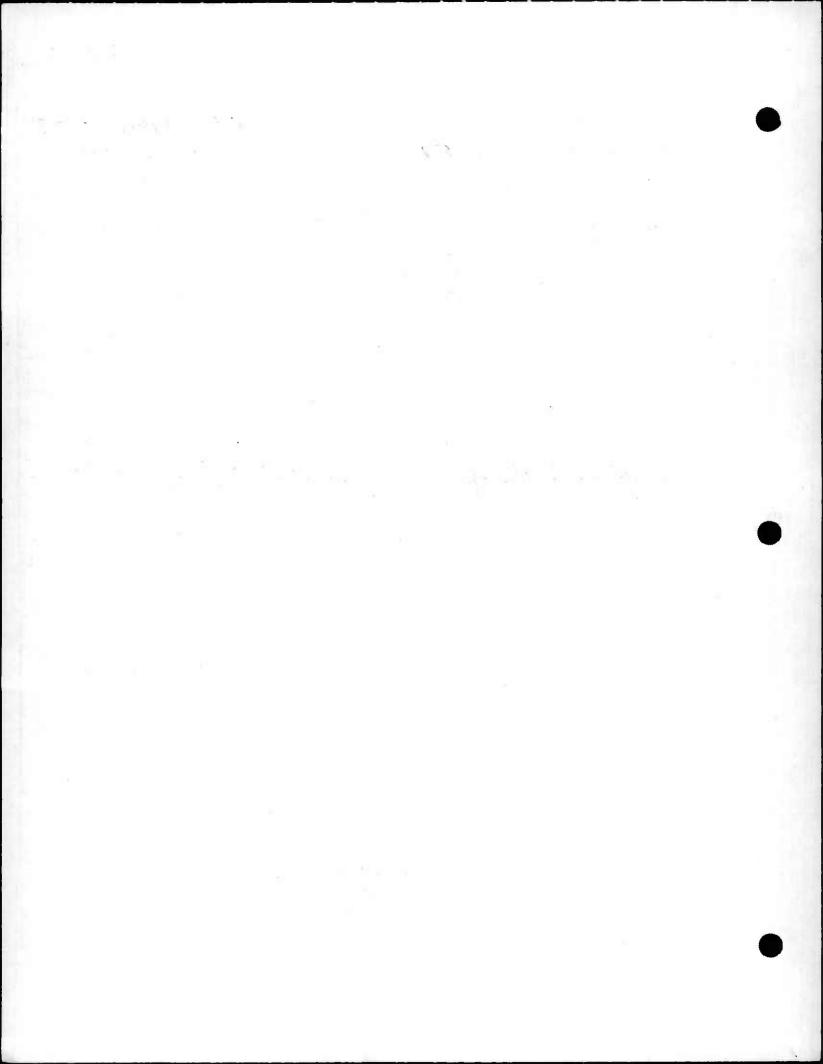
	FOR 1 - STATE	STATE OF MARYL	AND / DEPAR	RTMENT OF	HEALTH AND	MENTAL HYGIEI		23	201	
	1. DECEDENT'S NAME (First, Middle, Lest)	uls St	e/zer	ICATE OF	DEATH	2. DATE OF DEATH		YEAR	TIME OF DEATH	
	094-09-0028	1 M 2 □ F 8	(In yrs. lest birthday) 4 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) April 12	1	BIRTHPLA Country)	CE (State or Foreign	
DIRECTOR	9a. FACILITY NAME (If not institution, give stree Washington County RESIDENCE OF DECEDENT		9b. CITY, TOWN OR LOCATION Hagerste		or Location of C					
	Maryland Washin	gton		Y, TOWN OR LOCA Hagerst					I. INSIDE CITY LIMITS? YES 2 NO	
FUNERAL	100. STREET AND NUMBER 250 Nottingham Road	d		11	01. ZIP CODE 2174	0	-	SA	COUNTRY?	
à	11. MARITAL STATUS 1 Never Married 2 🔀 Merried 3 Widowed 4 Divorced	FORCES? 1 X YES IF YES, GIVE WAR OR D. W.W.II, KO	S 2 NO tt yes, specify Cuben, Mexicol DATES 1 YES 2 NO Spec			Ican, Puerto Rican, etc.) Black, Whi			American Indien, hita, atc.	
7.55	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	CION mpleted) College (1-4 or 5+)	(Give kind of life. Do NOT u	USUAL OCCUPAT work done during m ee retired.) .sor/cla	nost of working	16b. KIND OF BU	S. Po		fice	
SE COMPLETED	17. FATHER'S NAME (First, Middle, Last) Lawrence Stelzer				16. MOTHER'S N	AME (First, Middle, Maider Sschwizer	n Sumame)	SC 01	Tice	
TO B	190. INFORMANT'S NAME (Type/Print) Annice P. Stelzer		1			Hagerstow			0	
	20s. METHOD OF DISPOSITION 1	t from Stata 20b	PLACE AND DATE	of Disposition (A	tory 7		cation - ch			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740									
	23. PART I. Enter the diseases, Dr conshock, Dr heart feliure. Lie IMMEDIATE CAUSE (Finel disease Dr condition resulting in death)	AS MICE	the deeth. Do oech line.	not enter the m	ode of dying, su	ch es cardiec Dr reep	olratory arres	it,	Approximate Interval Between Onset and Deat	
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST	6	CONSEQUENCE OF						Chronic	
MEDICAL	PART II. Other significent conditions of	which has	nt dis	fus(1 Part I. 24s. WAS AF PERFO		AWAI COA DF I	RE AUTOPSY FINDINGS ILABLE PRIOR TO APLETION OF CAUSE DEATH? YES 2 \(\sum \) NO	
BY PHYSICIAN: MEC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER									
	1 PRS 2 NO 1 27. MANNER OF DEATH 1 Netural 5 Pending	tnpatient 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year)	Y 28b. TIME OF 28c. INJURY AT			28d. DESCRIBE HOW INJURY OCCURED				
	2 Accident investigation 3 Suicide e Could not be detarmined	28e. PLACE OF INJURY — At home, farm, atreet, factory, offica building, etc. (Specify)				281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
O BE COMPLET	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.									
	29b. SIGNATURE AND TITLE OF CERTIFIER	00	redo 1	1	29c. LICENSE NU	000 1 7	29d. DATE S	GIGNED (Mon	oth, Day, Year)	

1110



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENT	AL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.						
		1. DECEOENT'S NAME (First, Middle, Lest) GEORGE WILLIAM SHRADER 2. DATE OF DEATH ONT 7 - 21-1995 5:00 PM					
P		4. SOCIAL SECURITY NUMBER 5. SEX 705-14-0104 1X0212-F 8. AGE (In yrs. last birthdey) WONTHS DAYS HOURS MIN. 8. BIRTHPLACE (State or Foleign Month) AUGUST 25, 1907 MARYLAND					
I, 2, 3 shoul	0 E	9a. FACILITY NAME (If not institution, give atreet and number) WASHINGTON COUNTY HOSPITAL 9b. CITY, TOWN OR LOCATION OF DEATH WASHINGTON WASHINGTON					
t. Pages 1,	DIRECTOR	PRESIDENCE OF DECEDENT 108. STATE 106. COUNTY MARYLAND WASHINGTON 106. CITY, TOWN OR LOCATION HAGERSTOWN WES 2 □ NO					
n. ansit perm	FUNERAL	106. STREET AND NUMBER 112 EAST WASHINGTON STREET 107. ZIP CODE 21740 109. CITIZEN OF WHAT COUNTRY? U.S.A.					
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should notified at once.	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES WILD DIVORCED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, epecify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. Specify: WILD Specify: WHITE					
VD 2121(ospital or atterched for use a	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 10 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) INSTALLED ORGANS PIPE ORGAN MFG.					
MARYLAND 2 retained by the hospital 5 should be detached to notified at once.	l iii l	17. FATHER'S NAME (First, Middle, Lest) CHARLES TISSUE SHRADER 18. MOTHER'S NAME (First, Middle, Meiden Surrame) FRIDINGER					
P.O. BOX 68760 BALTIMORE, in certificate be executed within 24 hours after death. Page 6 may be ending physician and completely filled in by the funeral director, page ending those prior to busial, cremation, or removal.	TO B	19a. INFORMANT'S NAME (Type/Print) WILLIAM T. FAHRNEY 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 EAST HILLCREST ROAD, HAGERSTOWN, MD. 21742					
		20s. METHOD OF DISPOSITION 1() Burisi 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campaign of Part HAVEN PREST HAVEN PREST HAVEN PREST HAVEN O7-25-95 ACCORDING TO TOWN, State HAGERSTOWN, MARYLAND					
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE ANDREW K. COFFMAN FUNERAL HOME, INC. 40 E. ANTIETAM ST., HAGERSTOWN, MD. 21740					
	N	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. APPROCANCINITY of the Prochate colonic onset and Death Due to (or as a consequence or): Sequentially list conditions b. With Management and Coaqy of parthy					
	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.						
CORDS irres that the d signed by the Health and Mer	MEDICAL C	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH?					
has b Dept.	AN: W	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)					
F = = 5	PHYSICIAN:	EXAMINER? 1 YES 2 MO HOSPITAL: 1 Defitient 2 ER/Outpetlent 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)					
O # ## 2	ву Рн	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY MORK? 1 YES 2 NO 28d. OESCRIBE HOW INJURY OCCURED					
ISIC TTENOI TOR: A after d	8	3 Suicide 6 Could not be determined 26s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
보 그 오 ==	COMPLET	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.					
TO THE HOSPIT TO THE FUNERA be filed within 7	TO BE (296. SIGNATURE AND TITLE OF CERTIFIER WORD Prull 40 Punual Prupicia 29c. LICENSE NUMBER 29d. DATE SIGNED/(Month, Gay, Year) 7/22/95					
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typs. Print) ROBERT BYULL YOUR 1459 POTOMAC AVE, 1500 PERSONN					
		JUL 2 4 1995 Julia Succession Supplies					

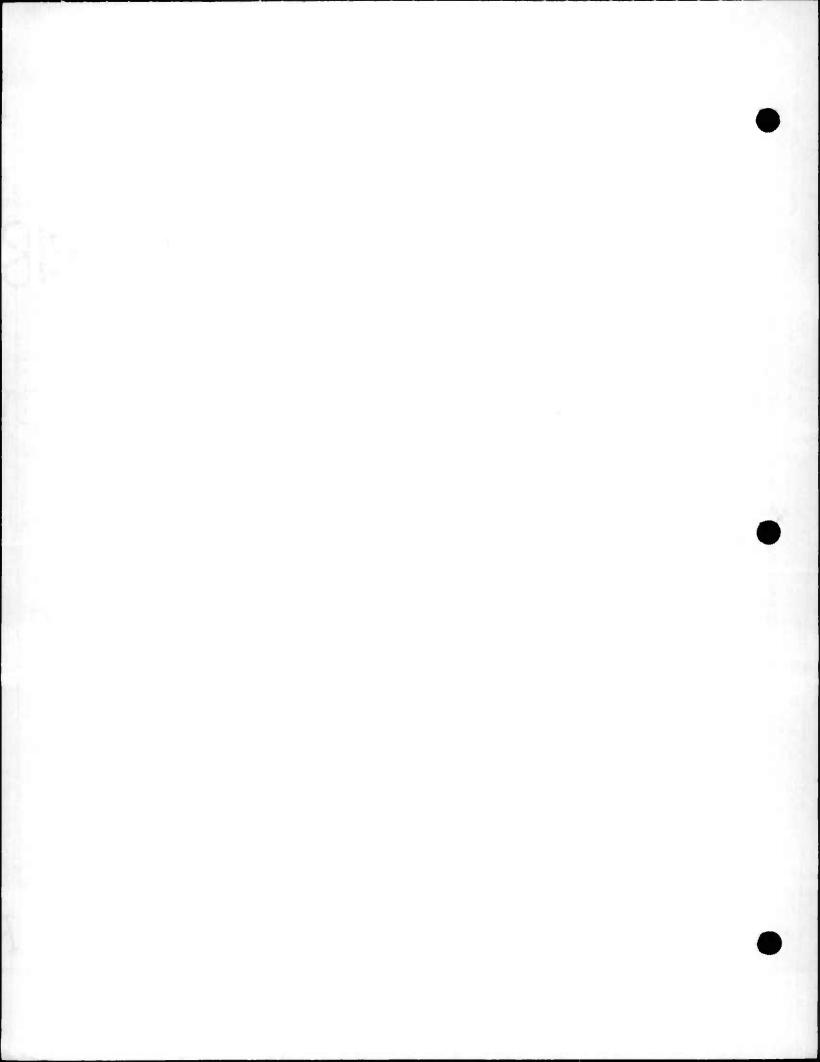


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE OF MARYLAND / DEPARREGISTRAR CERTIF	RTMENT OF HEALTH AND N	MENTAL HYGIENE									
	1. DECEDENT'S NAME (First, Middle, Last) Shelby Renee ST.CLAIR		2. DATE OF DEATH MONTH DAY July 20,	1005								
	4. SOCIAL SECURITY NUMBER 216-29-8038 5. SEX 1 M 2 X F 4 YRS.	IF UNDER 1 YEAR IF UNDER 24 MRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 25, 19	6. BIRTHPLACE (State or Foreign Country)								
OB	90. FACILITY NAME (if not institution, give street and number) 737 Washington Avenue	9b. CITY, TOWN DR LOCATION OF OEA Hagerstown		9c. COUNTY OF DEATH Washington								
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. CDUNTY 10c. CIT	Y, TOWN DR LOCATION		10d. INSIDE CITY								
		Hagerstown		LIMITS?								
FUNERAL	10e. STREET AND NUMBER 737 Washington Avenue	101, ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?								
S	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED	21740 13. WAS DECENDENT OF HISPANI	C ORIGIN? (Specify Year	Dr. No.— 14. RACE — American Indian.								
B	1 Never Married 2 ☐ Merried Merried FDRCES? 1 ☐ YES 2 ▼ NO IF YES, GIVE WAR OR DATES IF YES, GIVE WAR OR DATES	If yes, specify Cuben, Mexicen 1 ☐ YES 2 疑 ND Specify:	, Puerlo Ricen, atc.)	Black, White, etc. Specify: White								
Ë	(Specify only highest grade completed) (Give kind of the Do MOT to	USUAL OCCUPATION work done during most of working	16b. KIND OF BUSH	NESS/INOUSTRY								
COMPLETED	College (1-4 or 5 +) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	raniou.y	none									
8	17. FATHER'S NAME (First, Middle, Last)		IE (First, Middle, Maiden St									
38	Victor Martin St.Clair, Jr. 190. INFORMANT'S NAME (Name Print)		ichelle Mas									
2	Victor M. St.Clair, Jr. 737 W	ashington Ave., l										
	20e. METHOD OF DISPOSITION MT Burlei 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Hill Cemetery 7-24-95 Hagerstown, Maryland											
Î	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACE MINNICH FUNERAL	ILITY	igerscown, mary rand								
	Det /h. Munich	415 E.Wilson B	lvd.,Hagers	stown.Md.21740								
	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEDUENCE OF):											
CERTIFICATION	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (or AS A CONSEDUENCE OF): c. DUE TO (DR AS A CONSEDUENCE OF): d.											
CAL C	PART II. Other algorificant conditions contributing to death but not resulting	in the underlying cause given in P										
DIC			PERFORM 1 TYES 2	COMPLETION DE CAUCE								
MED!	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YE	S EL NO EL NIGORIO		1 TES 2 NO								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEAT		ш									
Sic	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA	OTHER: 4 Nursing Home 5 Residence 6	□ Other (Specify)									
ВУ РН	27. MANNER-OF DEATH 1 Natural 5 Pending (Month, Day, Year) 286. OATE DF INJURY (Month, Day, Year) 1 Natural 1 Nat		28d. OESCRIBE HOW INJ	JURY OCCUREO								
a	3 Suicide 8 Could not be determined 28e. PLACE DF INJURY — At home, farm, a building, etc. (Specify)	street, factory, office	26t. LOCATION (Street end City or Town, State)	d Number or Rural Route Number,								
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurrence one) 2 MEDICAL EXAMINER: On the best of examination end/or investigation											
8	296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. OATE SIGNED (Month, Day, Year)											
2	Julia D Oakhy M.											
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 32. REGISTRAR'S SIGNATURE 32. REGISTRAR'S SIGNATURE												



1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY Catherine C. Turpin YEAR July 12. 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 219-07-2055 84 July Ti, 1911 Maryland 1 M 2 X Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 207 Tilghman street DIRECTOR Oxford Talbot RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 19c. CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Talbot Oxford 1 1 YES 2 | NO permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 207 Tilghman Street 21654 USA use as the burial-transit retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 TYNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Married BY Specify: Black 3√ Widowed 4 □ Divorced 9 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY COMPLET n/Secondary (0-12) page 5 should be detached for College (1-4 or 5+) Domestic Domestic 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Harrison Ross Lillie. Landman 76 BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 David Ross Cooper 4957 Screamersville Rd., Oxford, Maryland 21654 after death. Page 6 may be e 20s. METHOD OF DISPOSITION

↑♥☐ Burlel 2 ☐ Cremetion 3 ☐ Removal from State

♣ ☐ Donation 5 ☐ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must funeral director, Screamersville Cemetery 7-19-95 Oxford, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Bennie Smith Funeral Home 420 Dover Street, Easton, Maryland n by the f medicai completely filled in by rial, cremation, or remo-23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiec or respiratory errest, del Approximate OURS shock, or hasrt failure. List only one ceuse on each line Interval Between Onset and Death IMMEDIATE CAUSE (Final the disesse or condition HYPERTROPHIC CARDIOMY OPATHY UTAR resulting in death) traumatic event. DIVISION OF VITAL RECORDS, P.O. BOX 68760. DUE TO (OR AS A CONSEQUENCE OF): requires that the death certificate be executed with attending physician and con ntal Hygiene prior to burial, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, isading to immedista Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST 6 n signed by the attent f Health and Mental H PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? HROME RENT INSUFFICIENCY any 1 YES 2 NO Shows ARDIAC CIRRHOSIS 1 YES 2 NO been : ORGULOPATHY PHYSICIAN: OR ATTENDING PHYSICIAN: The law of DIRECTOR: After this certificate has be hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 YES 2- NO 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c, INJURY AT 26d. DESCRIBE HOW INJURY OCCURED with t marked. 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 40 3 Suicide COMPLETED 6 Could not be 4 Homicide 28 Hem 29e. CERTIFIER

Thack and

Terrifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner ee stated. FUNERAL I HOSPITAL 2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner se stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1 29b. SIGNATURE AND TITLE OF CENTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2396 7.13. 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Scott D. Friedman, 403 Marvel Court, Easton, Md. 21601

32: REGISTRAR'S SIGNATURE

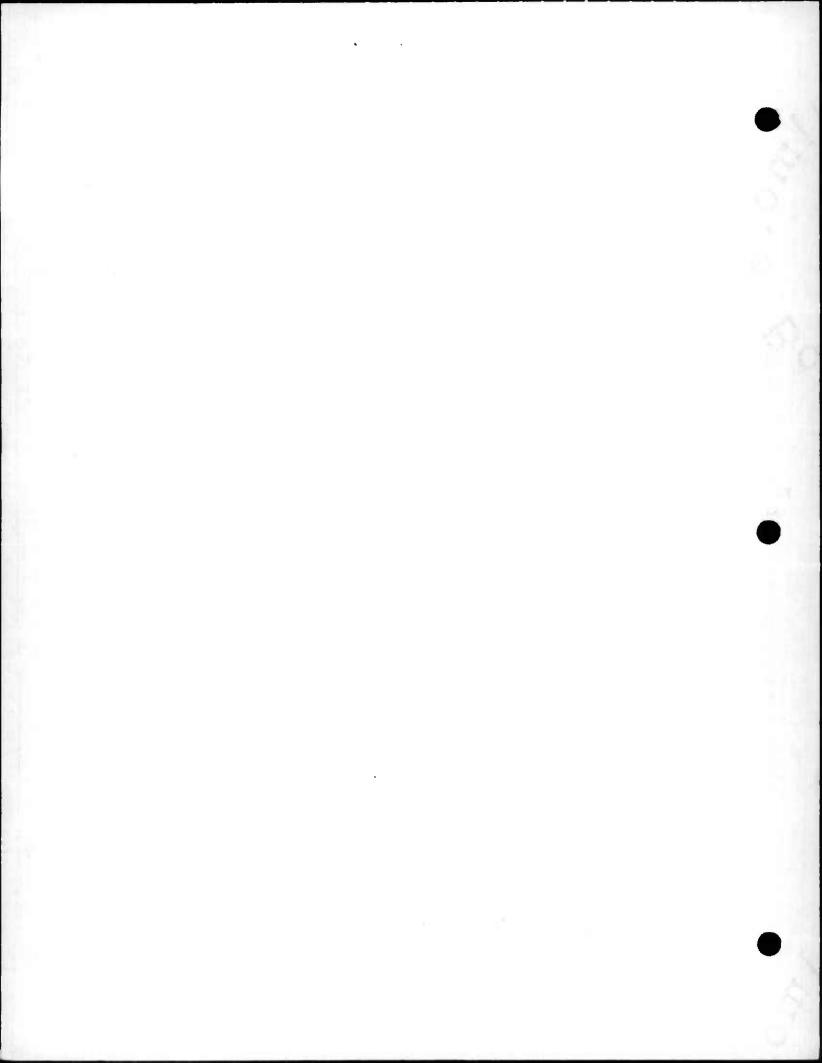
31. DATE FILED (Month, Day, Year)

JUL 14 1995

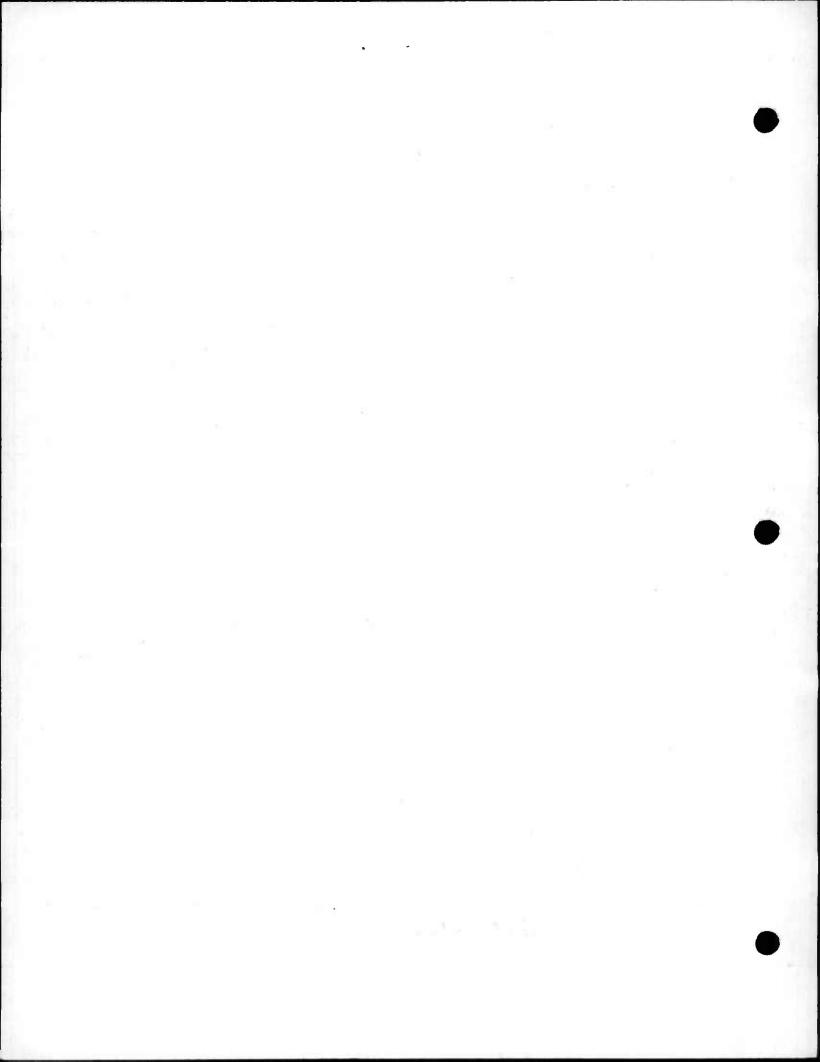
449612 RENDE INSTETICIENCY

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE OF MARY	LAND / DEPARTI	MENT OF HEALTH AND CATE OF DEATH	MENTAL HYGIENE REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY	3. TIME OF DEATH						
	Robert Lee		THUMAS	JULY 17,	11- 62 (-)						
	4. SOCIAL SECURITY NUMBER 5. SEX 0. AGI 1XXM 2 □ F		F UNDER 1 YEAR IF UNDER 24 HRS, DNTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)						
	9a. FACILITY NAME (If not institution, give street and number)		b. CITY, TOWN OR LOCATION OF D	Feb. 16, 1							
DIRECTOR	PENINSULA REGIONAL MEDICAL C		SALISBURY	EATH	9c. COUNTY OF DEATH WICOMICO						
REC	10e. STATE 10b. COUNTY	10c. CITY, 1	TOWN OR LOCATION		10d. INSIDE CITY						
0	Maryland Wicomico 10e. STREET AND NUMBER	Pac	onoke.		1 - YES 2 H NO						
BY FUNERAL	2611 Lamberton Rd.		10f. ZIP CODE 21851		10g. CITIZEN OF WHAT COUNTRY? USA						
NO.	11. MARITAL STATUS 1 Never Married 2 ™ Married FORCES? 1 ☐ YE	IN U.S. ARMED	13. WAS DECENDENT OF HISPA								
BY	1 Never Married 2 Married FORCES? 1 YE 3 Wildowed 4 Divorced IF YES, GIVE WAR OR	DATES	If yee, specify Cuben, Mexico		Specify: Black						
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S US	SUAL OCCUPATION	16b. KIND OF BUSI	INESS/INDUSTRY						
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+)		k done during most of working etired.)	01 . 1	77						
MP	12th 17. FATHER'S NAME (First, Middle, Last)	Laborer			en Factory						
	Monroe Preston Thomas			ME (First, Middle, Melden S e Mae Belot							
TO BE	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING AT	DDRESS (Street and Number or Rural	Route Number, City or Town,	. State, Zip Code)						
F	Selena Thomas		Lamberton Rd,								
	II 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State	Ob. PLACE AND DATE OF I	nlanel		ATION — City or Town, State						
	21. SIGNATURE OF FUNERAL SERVICÉ LICENSEE	JIIII U.	Church Cem.	1/22/195	Pocomoke, Md.						
	>		Bennie Smi	th Funeral	Services , Md. 21601						
	23. PART I. Enter the diseases, or complications that causehock, or heert failure. List only one cause on	ed the death. Do not	enter the mode of dying, aud	h as cardiac or respire	atory arreat, Approximete						
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Recurrent Venthieulan Tachycandia, Due to (or as a consequence or): Acute My candial Infanchim.										
z	Leute Myo candial Infaretion.										
0T	if any, leading to immediate	A CONSEQUENCE OF:									
S	CAUSE (Diseese or Injury	A CONSEQUENCE OF:	thoroseler	081.							
CERTIFICATION	that initiated eventa resulting in deeth) LAST	A CONSEQUENCE OF):									
	DART II Other significant and Many and Many										
CAL	PART II. Other significent conditions contributing to death	but not reculting in	the underlying ceuse given in	Part I. 24s. WAS AN A PERFORM	MED? AMAILABLE PRIOR TO						
MEDICAL	PVC			1 TES 2	OF DEALER!						
	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YES	□ NO □ UNCERTAI	<u> </u>	1 _ YES 2 _ (NO						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEATH	(Check only one)								
YSI	1 YES 2 NO 1 Inpatient 2 ER/Ou	tpatient 3 DOA 4	THER: Nursing Home 5 Residence	6 Other (Specify)							
E	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year)			26d. DEŞCRIBE HOW IN.	JURY OCCURED						
) BY	2 Accident Investigation 3 Suicide 8 Could not be 26e. PLACE OF INJUR	TY At home, ferm, stre		28f. LOCATION (Street and	nd Number or Rural Route Number,						
COMPLETED	4 Homicide determined building, atc. (Sp	selfy)	-0.50-0.00-0	City or Town, State)							
7	29e. CERTIFIER Check only CERTIFYING PHYSICIAN: To the best of my kno	wledge, death occurred a	it the time, date and piece, and due	to the cause(a) and mann	or ee stated.						
SON	MEDICAL EXAMINER: On the beals of examination	on and/or investigation, i	in my opinion, death occured at the	time, data and place, and	due to the cause(a) and manner as stated.						
BE	280, SIGNATURE AND TITLE OF CERTIFIER Whole	9 MD	29c. LICENSE NUI	WBER	29d, DATE SIGNED (Month, Day, Year)						
2	16. HARRE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF D	EATH (ITEM 27) (Type, Pri	en share d	hive .st	HLIBURY MG						
	31. DATE FILED (Month, Day, Year) 32. REGISTRAN'S SIG				0						
	JUL 2 0 1995 Jahr Dave	near mardell									

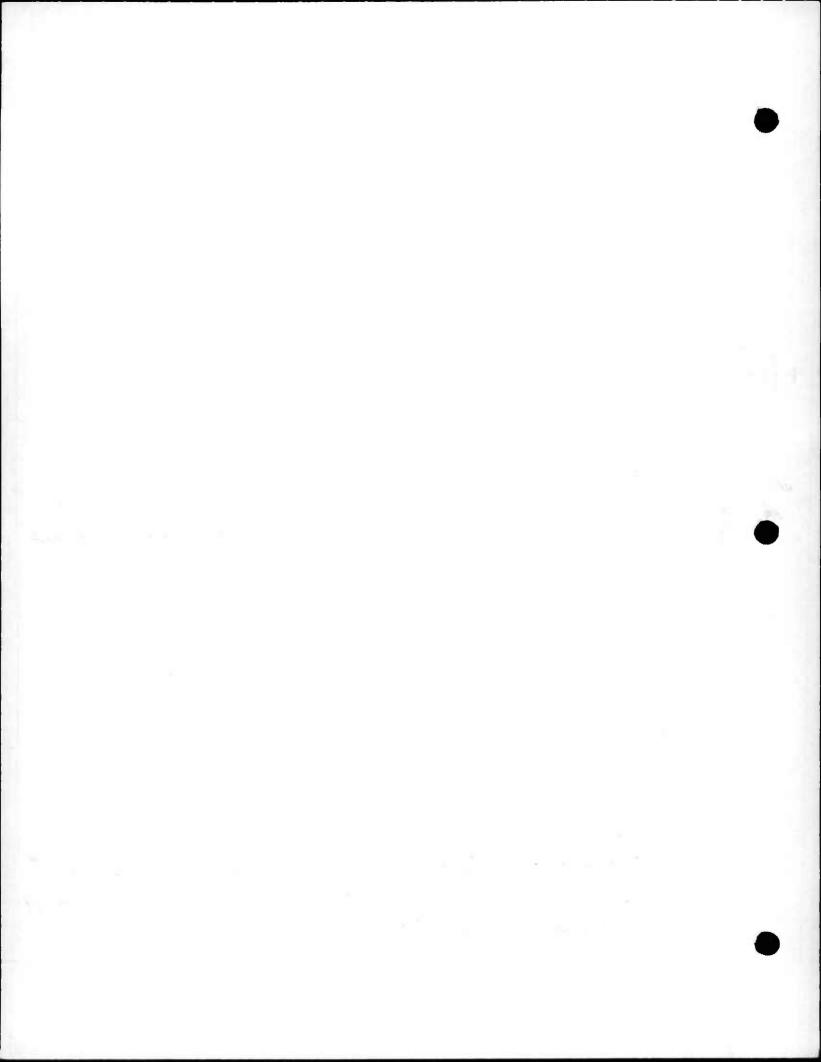


		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF I	HEALTH AND I		HYGIENE REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF		VE	3. TIME OF DEATH	_
		CARROLL THORNTON					July	z 04	1995	2240	M
				(In yrs. last birthdey)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, E		8. B	HRTHPLACE (State or Foreign country)	
pinous		216-60-8159 1 9a. FACILITY NAME (If not institution, give street	M 2 F	42 YAS.			Jan. 3		53 Ma	rvland	
es.	<u>E</u>	107 Dellfox Road				OR LOCATION OF DE	EATH	9	c. COUNTY C		
1, 2,	ЕСТОВ	RESIDENCE OF DECEDENT	<u>a</u>		Barl	ay			Que	een Anne's	
Pages	DIRE	10e. STATE 10b. COUNTY			TY, TOWN OR LOCA	TION				10d. INSIDE CITY LIMITS?	_
permit. F	1 1	Maryland Kent 100. STREET AND NUMBER		F	airlee					1 📉 YES 2 🗌 NO	
sit pel	RA	Baywood Court, Ap	x+ 7		10	21620		1		OF WHAT COUNTRY?	
15-0020 ending physician, as the burial-transit	FUNERAL		2. WAS DECEOENT EVER IN	N U.S. ARMED	13, WAS DEC	CENDENT OF HISPAN	UC OBIGINS (C-colfu Vac or	USA	RACE — American Indian.	_
020 physi		1 Never Married 2 Married	FORCES? 1 YES	2 ZNO	It yes, sp	pecify Cuban, Mexica	n, Puerto Rici	in, atc.)		Black, White, atc.	
5-0 nding as the	D BY	3 Wildowed 4 Divorced	7.			S 2 NO Specify	<i>r.</i> 			Specify: Black	
21215-0020 al or attending physician, for use as the burial-tra	ETEC	15. DECEDENT'S EDUCATI (Specify only highest grade con	1ON npleted)	(Give kind of	Work done during me	ON ost of working	16b. KI	ND OF BUSIN	SS/INDUSTP	ŧY.	
D 2			College (1-4 or 5+)	life. Do NOT u.			,	Ca		1	
AND the hospital detached for once.	СОМР	17. FATHER'S NAME (First, Middle, Last)		Labore	<u></u>	16. MOTHER'S NA		awn Ca		ker	_
3 E & Z	ш	Lengard Edward T	harntan			1		Brown	,		
MARYL retained by to 5 should be notified at	80	19a. INFORMANT'S NAME (Type/Print)	ROTHLOR	19b. MAILING	G ADDRESS (Street)	and Number or Rural F				9)	_
	2	Mary Hicks				rt, Apt.				21620	
IMORE, Page 6 may be all director, page		20a. METHOD OF DISPOSITION 1 □ Burlet 2 □ Cremation 3 □ Removal		PLACE AND OATE	OF DISPOSITION (No		DATE	_		or Town, State	-
Page 6 ma al director, p		4 1 Donation 5 Other (Specify)	M	lt. Olive	e A.M.E.	Cemetery	7/8/	95 Bu	tlert	own. Md.	
£ 5 E		21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE		22. NAME AI	ND AGORESS OF FAC	CILITY				
BALT er death. the funera val. ii examir		150				ie Smith Box 1687					Ì
hours after ed in by the or removal		23. PART i. Entar the diseases, or com ahock, or heart fallure. List	pilications that caused	tha death. Do	not enter the mo	oda of dying, auci	h as cardiad	or raspirate	ory arreat,	Approximata	-
filled in		IMMEDIATE CAUSE (Final		*						intarval Batween Onset and Daath	
= a te =		disease or condition resulting in death)	Multiple								
B 5 2 5			DUE TO (OR AS A	COMSEQUENCE O	F):						
OX 68 e be execut sician and c infor to buris traumatic	ERTIFICATION	Sequentially list conditions, b	DUE TO (OR AS A	CONSEQUENCE O	NETA-						-
or t or	CAT	if any, leading to immediate cause. Enter UNDERLYING		001102002	rj.						
certificate ding physical sygiene pri	Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	F):						-
T = 2 = 9	EH	resulting in death) LAST									
E & B & S	0	PART II. Other algolificant conditions of	ontributing to death br	ut not resulting	in the underlying	a ceuse given in	Dart I 24	a. WAS AN AUT	maey	ATT MERCH ANTONOM EMPIRION	_
- 6 - 6 -	CAI			at hot tooming	III tile thideliyar	g causa givaii ai		PERFORME	D?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE	
requires the signed of Health shows are	MEDIC						— ¹	YES 2 [NO	OF DEATH?	
>	≥ ;	DID TOBACCO USE CONTRIB	UTE TO CAUSE O	F DEATH YE	ES I NO I	UNCERTAIN	<u>_</u> _			1 YES 2 NO	
- S & S O O I	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT		J OIACEKIPAII					-
SICIAN: The certificate he state he state he or item	SIC		OSPITAL:	etlent 3 DOA	OTHER: 4 Nursing Hom	ne 5 🗆 Rasidence	8 XOther (S	necify) at	sce	ne	1
OR ATTENDING PHYSICIAN: The OR ATTENDING PHYSICIAN: The ORIECTOR: After this certificate hy your after death with the State Diem 28 is marked, or Item	HH	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJ			BE HOW INJU			1
ONG PHYS After this of death with	BY	1 Natural 5 Pending 2 Accident Investigation	7/4/95	9:30	OPM 1 U	YES 2 R NO	Pedes	trian .	struck,	by automobile	Ì
ATTENDING After S after death	8	3 Suicide 8 Could not be determined	26a. PLACE OF INJURY building, atc. (Speci	(AN)	street, fectory, office	•	281 LOCATIO	DN (Street end)	Number or Ru	ral Route Number,	1
OR ATTENOING ORECTOR: After hours after death		an order		Street			RT 213	North o	of Chur	sh Hell	
목가스트	COMPL		N: To the beat of my knowle								
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	00	2 X MEDICAL EXAMINER: O	in the basis of examination	and/or investigation	on, in my opinion, d	leath occured at the	time, data and	d place, and du	a to the caus	se(a) and manner as stated.	
THE F	BE	29b. SIGNATURE AND TITLE OF CERTIFIER	1			29c. LICENSE NUM	BER	29	d. DATE SIGN	NED (Month, Day, Year)	1
₽ ₽ ≥ ₹	2	30. NAME AND ADDRESS OF PERSON WHO CO	Might MD			0.C.1	M.E.		Jul	y 05 1995	
		Daniel									
		31. DATE FILED (Month, Day, Year)	MD 62. REGISTRAB'S SIGNA	TIII P	enn St	reet, B	altim	ore,	Mary	land 21201	4
		JUL 11 1995	who dhuckers								ı



्टै BALTIMORE. MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 1 - FOR STATE REGISTRAR

	_	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF		MENTAL	HYGIEN				
		1. DECEDENT'S NAME (First, Middle, Last	,				2. DATE	OF DEATH	AY Y	EAR 3.	TIME OF DEATH	
		Dmytro Martin	Telenson				July		1995		5:40 A	A
		4. SOCIAL SECURITY NUMBER	40000	(in yrs. last birthday)	MONTHS DAYS		7. DATE ((Month)	OF BIRTH , Day, Year)	8.	BIRTHPL/ Country)	ACE (State or Foreign	n
용		171-12-5434		7 YRS.				5, 19			ylvania	
3 sho	CC	9a. FACILITY NAME (If not institution, give				OR LOCATION OF D	DEATH		9c. COUNTY	OF DEAT	Н	
2,	DIRECTOR	1534 Andover La	ne		Fred	erick			Fred	leric	k	
ges	l m	10a. STATE 10b. COUN	TY	10c. Cl	TY, TOWN OR LOC	ATION				10	d. INSIDE CITY	-
ج <u>ن</u> ح	a	PA Wes	tmoreland		Jeannet	te				1	LIMITS?	
physician. burial-transit permit. Pages 1, 2, 3 should	\¥	10e. STREET AND NUMBER				Of, ZIP CODE			10g. CITIZEI	OF WHA	T COUNTRY?	-
ansit	FUNERAL	112 Thirteenth				15644	4		υ	SA		
physician. burial-tran	5	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER I	N U.S. ARMED		ECENDENT OF HISPA specify Cuban, Mexic			or No- 14	. RACE —	American Indien, hita, atc.	_
te p	B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES		S 2 NO Speci		active attention		Specify:		
as end		15. DECEDENT'S ED	UCATION UCATION	16a DECEDENT'S	S USUAL OCCUPAT	HON	105	KIND OF BUIL	SINESS/INOUS		white	_
50 %	ETED	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4 or 5+)		work done during nuse retired.) Ch		100.	KIND OF BU	SINESS/INUUS	INT		
hospital ached fe	릴	12	7		of Ort			rthod	ox Rel	iaio	n	
be detached	COMPL	17. FATHER'S NAME (First, Middle, Last)			01 010	18. MOTHER'S N				IEIU	11	-
a pe	4.1	Daniel Telencie	0			Anna	Minto)				
should be should notified	TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAJLIN	G ADDRESS (Street	and Number or Rural	-		n, State, Zip Co	de)		
ny be re page 5	-	Paul Telenson		70 Bu	ckland 1	Dr., Nesh	nanic	Stati	on, NJ	088	53	
e 6 may ector, pa		20a. METHOD OF DISPOSITION Companies 2 Cremation 3 Re-	movel from State 20t	netery, cremetory or	OF DISPOSITION //		OATE		CATION — CITY			
Page 6		4 □ Donation 8 □ Other (Specify)	St	. Michae	1s Ceme			Irw	in, PA			
death. Pag s funeral di f. examiner	Ш	AL SIGNAL OF PURENCE SERVICE S	J. S. S. S. S. S. S. S. S. S. S. S. S. S.			and address of Fun		Homes	РΔ			
		Jany X.	FX	2	P.O.	. Box 181	9. Fr	ederi	ck. MD	217	02	
hours after of in by th or remova	(23 PART I. Enter the disease, or shock, or heart failure	complications that cause. List only one cause on a	the deeth. Do	not anter tha m	ode of dying, suc	ch aa cardi	iac or reapi	iretory erreal	,	Approximate	
y filled in the trion, or red		IMMEDIATE CAUSE (Finel									Onset and Da	
ertely emati		disease or condition reaulting in death)	ARTERIOS			RDIO WAS	LLAA	e Di.	SEASE	5	YEAR.	S
executed with and completely fille o burial, cremation, matic event, the			DUE TO (OR AS A	A CONSEQUENCE C	OF):							
ertificate be executing physician and orgiene prior to buri	NO N	Sequentielly list conditions,	b. OUE TO (OR AS A	CONSEQUENCE C	ne.							_
ysician prior t	CATION	if any, leading to immediate cause. Enter UNDERLYING		· vollocouchoc o	, ,.							
tificat phy ene phy	正	CAUSE (Disease or injury that initieted events	DUE TO (OR AS A	CONSEQUENCE C	OF):							_
. 5 5 E	ITI	resulting in death) LAST	d									
the death y the attended Mental H injury, or	L CEI	PART II. Other significent condition	one contributing to death b	ust most manufelina	In the contest to		- · · · T					_
y is			The contributing to death b	or nor readiting	in the undariyii	ng cause given in	Part I.	24a, WAS AN PERFOR		AW	RE AUTOPSY FINDIN VILABLE PRIOR TO	
w requires the been signed pt. of Health 3 shows an	MEDI							1 YES 2	NO		MPLETION OF CAUS DEATH?	E
requires been sign of Healt	Σ	DID TOBACCO USE CON	TDIRLITE TO CALISE O	E DEATH V	ES [] NO [UNCERTAI	N. C			1 [YES 2 NO	
N 6 8 5	SICIAN:	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF OEA			ИПТ					
SICIAN: The certificate h the State I	SIC	EXAMINER? 1 X YES 2 \(\backsquare \) NO	HOSPITAL: 1 Inputient 2 ER/Outs	patient 3 DOA	OTHER:	me 5 Realdence	. □ Other	(Specify)				-
rSiCIA s certif th the	PHY	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. Til	AE OF 28c, IN	IJURY AT	1		NJURY OCCUR	EO		_
NG PHYS fter this cath with	BY	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	IN.		YES 2 NO						
R: After er death		3 Suicide 8 Could not be	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm,	atreet, factory, offi	ce	281. LOCA	TION (Street a	and Number or	Rural Route	Number,	_
DR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate his hours after death with the State E tem 28 is marked, or Item		4 Homicide detarmined					0.17 0.1	, jown, State)				
	MPLET	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my know	ledge, death occur	red at the time, dat	a and place, and due	a to the caus	e(a) and man	nner as stated.			_
HOSPITAL FUNERAL WITHIN 72 TANT: II	CO	one) 2 MEDICAL EXAMIN	IER: On the beals of examination	n and/or investigation	on, in my opinion,	death occured at the	time, date a	and place, an	d dua to tha co	Ruse(a) an	d manner as atated	i.
H H H B B H H H H H H H H H H H H H H H	BE	290 STONATURE AND TITLE OF CERTIFIE	FD 1+	MAN		29c. LICENSE NU	MBER		29d. DATE SI	GNEO (Mo	nth, Day, Year)	_
TO THE HOSPIT TO THE FUNERA DE filed within 7 IMPORTANT: 1	TO B	Corner RX	- Kopers	M		D098	67		> Ju	LY	17 1995	_
	F	30. NAME AND ADDRESS OF PERSON W	M . "	ATH (ITEM 27) (Type	Print)				141		01-459	_
		KKK KO BER				FRED	ERI	44	my -	217	01-459	×
		31. DATE FILED (Month, Day, Year)	32. RIPGISTRARIS SIGN	ATURE POLL H	i							
		JUL 1 9 199	J		4.							



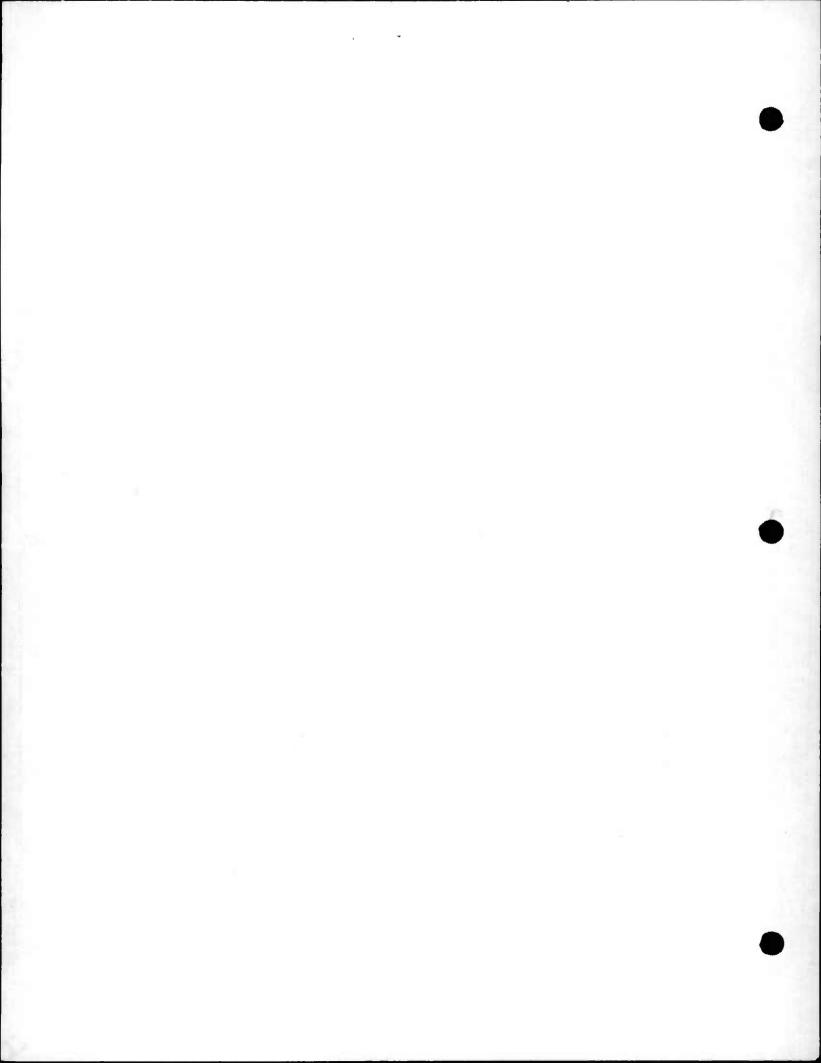
1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)

Maildie Esther Thompson

2. Date of Death MONTH MONTH DAY

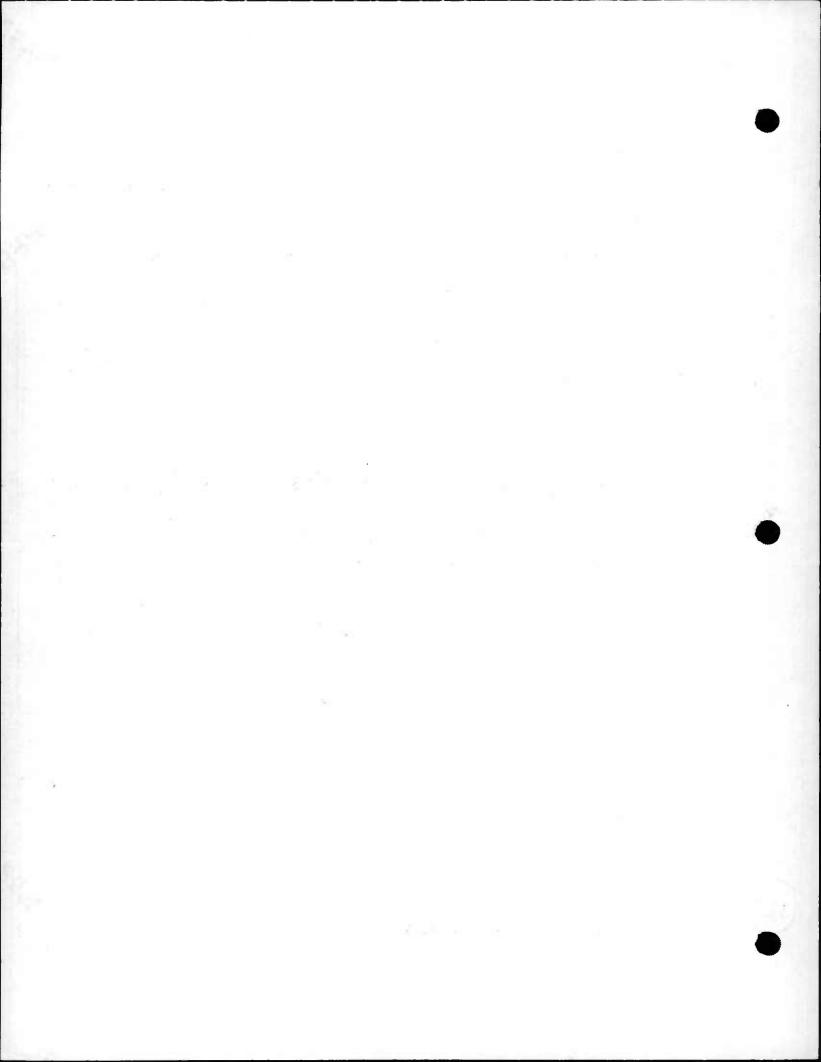
		1. DECEDENT'S NAME (First, Middle, Last) Maudie Est	her Thomp	son				- 1	DATE OF DEATH DAY	1995	YEAR	TIME OF DEATH
P			1 🗌 M 2 🔼 F	(In yrs. lest bii 64	YRS. MONTH			HRS. 7.	DATE OF BIRTH (Month, Day, Year) /21/193	1	8. BIRTHPLA Country)	NC (State or Foreign
1, 2, 3 should	TOR	98. FACILITY NAME (If not inetitution, give sin 1345 South View RESIDENCE OF DECEMENT	Rd.			lewbu	er LOCATION	OF OEAT	Н		arle:	
Pages	DIRECTOR	MD 106. COUNTY Cha	rles	1	oc. city, tow Ne	wbur						1. INSIDE CITY LIMITS? YES 2 1 NO
ansit permit,	FUNERAL	1345 South Vie	w Rd.			101	2066	4			S.A	
17215-0020 or attending physician. r use as the bunal-transit	ВУ	11. MARITAL STATUS 1 Never Merried 2 TMarried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES		RMED NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Maxican, Puarto Rican, atc.) 1 VES 2 NO Specify: While, atc.					hile, atc.		
4 E	COMPLETED	15. DECEDENT'S EDUCI (Specify only highest grade of Elementary/Secondary (0-12)	ATION ompleted) College (1-4 or 5+)	(Give I life, Do	DENT'S USUAL kind of work dor NOT use retired Memak	ne during mo d.)			166, KIND OF BUSINESS/INDUSTRY Home			
3 6 6	BE CO	17. Father's Name (First, Middle, Last) Edmond Deese 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Sally Brooks Deese										
6) 60	5	198. INFORMANT'S NAME (Type/Print) Harold Thompson 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Coole) 1345 South View Rd. Newburg, MD 20664										
e 6 m rector,		20e. METHOD OF DISPOSITION 1 Greater 2 Cremation 3 Remon 4 Donation 5 Other (Specify)	rel from State	PLACE AND	DATE OF DISP	ty C	em.			noro	oke, I	TC
sALI death. e funera al. exami		21. SIGNATURE OF FUNERAL SERVICE LICE	Echol	M009	4.5 A	REHA	RT-E	CHOL	S FUNER	AL H	OME,	INC.
executed within an hours after and completely filled in by the oburial, cremation, or removal matic event, the medical	7	23. PART I. Enter the disease, or co shock, or heert failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	mplications thet cause ist only one cause on a	SCO	noke	-			a cerdiec or respir		est,	Approximete Interval Between Onset and Death
th certificate be ending physician I Hygiene prior to	CERTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d										
ires that the d signed by the fealth and Mer	MEDICAL	PART II. Other aignificent conditions							PERFORM	AED?	CON OF I	RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 \(\sum \) NO
The taw ate has that that that the Dept em 23	PHYSICIAN:		HOSPITAL:	26. PLACE O	F DEATH (Chec	ck only one)	M	RIAIN				
PHYSICIAL this certification with the with the inked, or		27. MANNER OF DEATH Naturel 5 Pending	1 Inpatient 2 ER/Outs 28a. DATE OF INJURY (Month, Day, Year)		Bb. TIME OF INJURY		-	28	Other (Specify) d. OESCRIBE HOW IN.	JURY OCC	UREO	
TTENDI CTOR; A after de	TED BY	2 Accident Investigation 3 Suicide 8 Could not be detarmined	28a. PLACE OF INJURY building, etc. (Spe	/ — At home,	Jerm, atreat, 1	actory, office		28	I. LOCATION (Street an City or Town, State)	d Number o	or Rural Route	Number,
	COMPLET		AN: To the best of my know									I manner as stated.
TO THE HOSPITAL TO THE FUNERAL Be filed within 72 IMPORTANT: If	BE	290, MONATUPE AND PSOCE OF CERTIFIER	mo dop	ute	M.E		29c. LICENS				SHOWED (Mor	1
	10	20. NAME AND ADDRESS OF VERNON WHO	hford M	8 70	00 C	old L	ine	Chr	±100 L	Wella	earl	MD 206%
		JUL 1 9 1995	32. REGISTRAR'S SIGN	ATURE SON	talle					, ,		



BALTIMORE, MARYLAND 21215-0020	Prours after death. Page 6 may be retained by the hospital or attending physician.	0 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760 & BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with reportations after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fur be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	TEGIOTTIAN		_		OFILLI	ICALL	_ 01	DEALL		REG. NO.			
	1. DECEDENT'S NAME (First,								2. DAT	E OF DEATH		YEAR	3. TIME OF DEATH
	MARCELLA	FEELY	WILLIAMS	S					Jul'			995	4:16 PM
	4. SOCIAL SECURITY NUME	ER	5. SEX	6. AGE (In yrs.	lest birthday)	IF UNDER		IF UNDER 24 HRS.		E OF BIRTH		6. BIRTI	IPLACE (State or Foreign
	480-20-803	5	1 M 2 K F	71	YRS.	MONTHS	DAYS	HOURS MIN.		nth, Day, Year)	1923	T OTT	
	90. FACILITY NAME (If not in	stitution, give str	eet and number)			9b. CITY	TOWN (OR LOCATION OF D		,		INTY OF E	
E G	Prince Geo	rge's	Hospital	Cente	r	Ch	Chever1v			Princ			George's
5	RESIDENCE OF DEC	EDENT									111	ince	dedige s
DIRECTOR	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN C	R LOCAT	TION					10d. INSIDE CITY LIMITS?
		Prince	e George'	S	E	rent	wood						1 X YES 2 NO
₹.	10e. STREET AND NUMBER						101	ZIP CODE			10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	3716 Taylo	r Stre	et					20722			U.	S.A.	- N
5	11. MARITAL STATUS		12. WAS DECEDENT FORCES? 1	EVER IN U.S.	ARMED	13.	WAS DEC	ENDENT OF HISPA ecity Cuben, Mexic	NIC ORIG	IN? (Specify Yee	or No-	14. RACI	E — American Indian, k, White, etc.
84	1 Never Married 2 3 Never Married 2 3 Never Married 2 Divo	IF YES, OIVE WA					2 NO Speci		Hicen, atc.)		Spec	lfy:	
	45 DECEDENTS COLLASION										White		
COMPLETED		highest grade o		16a.	Give kind of life. Do NOT us	Work done	during mo	ON st of working	16	b. KIND OF BUS	INESS/IND	DUSTRY	
ا ت	Elementary/Secondary (0	-12)	College (1-4 or 5+)										
× 1	43 FATHERIO MANE (C) . A		2	50	ecreta	ry	_					f Ag	riculture
BE	Thomas Michael Feely Cecelia Shannon Mac Cahill										1		
2	196. INFORMANT'S NAME (Type/Print) Dorothy Roberts 196. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6327 Riverdale Road, Riverdale, Maryland												
. 1									Rive	erdale,	Mar	ylan	d 20737
	20e. METHOD OF DISPOSITI	n 3 🗆 Remo	val from State	20b. PLAC	CE AND DATE	OF DISPOS	ITION (Na	me of	DA	TE 20c. LOC	CATION —	City or To	wn, State
	4 Donation 5 Other (Specify) Fort Lincoln Cemetery 7/19/95 Brentwood, Maryland												
	21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home,										o D A		
	L LUIS	s. G	0000										MD 20781
	23. PART I. Enter the di	seeses, Dr CD	implications that	ceused the	deeth. Do r	not enter	the mo	de of dving, aud	ch ea cei	rdiec or readir	ratory an	TIE,	Approximate
	ahock, or he IMMEDIATE CAUSE (Fin	part lellure. L	lat only one ceus	e on each i	ine.			41125				,	Interval Between
											Onset and Death		
	disease or condition resulting in death) a. CAN N/NC INSULT is early Due to (or as a consequence of):										1 1000		
_	CARDIN MAIN RATION											5 vni	
<u>o</u>	Sequentielly list conditi if sny, leading to immed		DUE TO (6	OR AS A CON	CONSEQUENCE OF):								1 (1)
¥.	cause. Enter UNDERLYI	NG	5	ENT	PTICEINIA								144
Ē	CAUSE (Disesse or inju that initiated events	γ <u> </u>			S A CONSCOUENCE OF):								+ / -
CERTIFICATION	resulting in deeth) LAS	T d.	7.	ZEN	=NAL INSUPPICIENCY								1 200
	DART II. Other elevities	A distant											
MEDICAL	PART II. Other significe	nt conditions	contributing to d	eeth but no	t resulting	n the un	derlying	g cause given in	Part I.	24a. WAS AN / PERFORI		24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă										1 TYES 2	NO		COMPLETION OF CAUSE OF DEATN?
2								,		,	,		1 YES 2 NO
ä	DID TOBACCO U	SE CONTR	IBUTE TO CAU	ISE OF DE	EATH YE	S 🗆 1	40	UNCERTAI	N□				
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	_	HOSPITAL:	26. PL	ACE OF DEAT								
YSI	1 TES 2 THO		1 Minpatient 2 🗆	ER/Outpetient	3 🗆 DOA	OTHER		e 5 🗆 Residence	8 🗆 Oth	er (Specify)			
H	27. MANNER OF DEATH		28e. DATE OF II (Month, Day		28b. TIM	E OF URY	28c. INJ	URY AT	28d. DE	SCRIBE NOW IN	JURY OC	CURED	
B		Pending nveatigation				М		ES 2 NO					
	3 Suicide 8 🗌	Could not be	28e. PLACE OF building, e	INJURY — At	home, term, s	treet, fecto	ory, office		28f. LO	CATION (Street ar	nd Number	or Rural F	loute Number,
H	4 Homicide	determined		1-1-1-77					City	or lown, stelle)			
ا يّ	290. CERTIFIER	IFYING PNYSIC	AN: To the beet of m	y knowledge.	death occum	ed at the ti	me date	and place, and due	to the co	use(e) end men	nor on elel	ad	
COMPLETED) end manner ee stated.
	296. SIGNATURE AND TITLE			-/			_	29c, LICENSE NUI					. 11 11 11 11 11 23 11 11 12 1
띪	())	(1) 4 1/4							4 -	/			(Month, Day, Year) \$-95
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CALLES	OF DEATH #	TEM 273 /3m-	Deint!		1050	7/			/ /	0 1)
	Dr. Roger I						η Δ37	enue #2	400	River	مادا	MD	20737
	31. DATE FILED (Month Day	func)	32 MEGISTRAD			WOL CI	. AV	- π Z	700,	VIAGIO	ale	, ru	20131
31. DATE FILED (Month, Day, Year) 32. MEGISTRAN'S SIGNATURE, JUL 19 1995 32. MEGISTRAN'S SIGNATURE,													



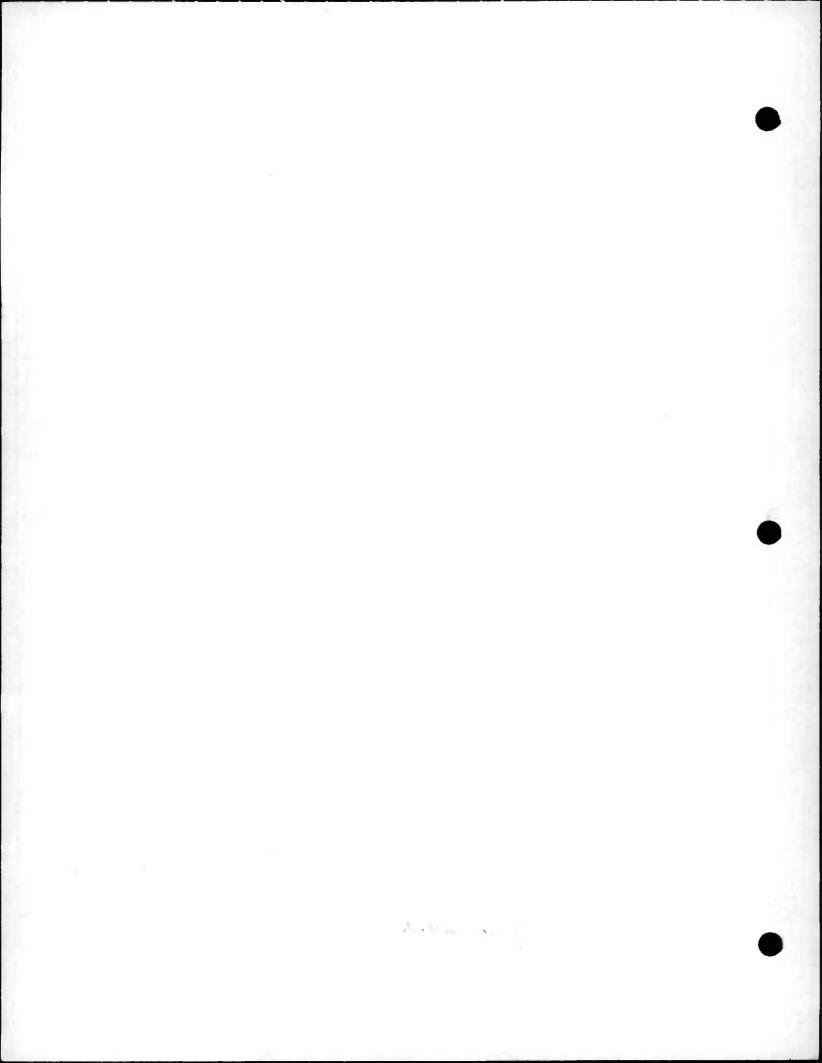
1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)

2. DATE OF DEATH

2. DATE OF DEATH

		1. DECEDENT'S NAME (First	, Middle, Last)			OLINI	ITICAT	_ 01	DLA		REG. NO		Ta	TIME OF DEATH
		CYNTHIA	ERCE	ELLE W	ILLI	AMS					MONTH D		YEAR	
		4. SOCIAL SECURITY NUME		5. SEX		yrs. last birtho	ley) IF UNDE	1 YEAR	IF UNDER	24 HRS. 7	July 16,1			ACE (State or Foreign
		578-60-4627		1 🗆 M 2 🔀 F	51	YR	B. MONTHS	DAYS	HOURS	MIN.	NOV 24,1	943	Country)	allilia esta casa.
2, 3 should		9e. FACILITY NAME (If not in	stitution, give s	treet and number)			96. CIT	r, TOWN C	OR LOCATI	ON OF DEAT			Mary TY OF DEA	
60	뜅	1910 Wether	bourne	e Court			Mit	chel	lvil	le		Princ	e Geo	orges
←	5	RESIDENCE OF DEC	10b. COUNTY											
-0020 Ing physician. The burial-transit permit. Pages	DIRECTOR	MD		e George	S		tchel	tchellville						M. INSIDE CITY LIMITS? YES 2 \(\text{\ballet} \) NO
per	₹	10e. STREET AND NUMBER					-							AT COUNTRY?
an. ransit	FUNER	1910 Wether	bourne	Court		20716			6		US	A		
20 rysicia	<u> </u>	11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDED	NAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO			WAS DEC	ENDENT C	F HISPANIC	ORIGIN? (Specify Yes	or No-	I4. RACE -	American Indian, Vhite, etc.
E S OI	ВУ	3 Widowed 4 Divo	rced	IF YES, GIVE	MAR OR DAT	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					fy: Specify			Lack
121 atter	ETED	15. DEC (Specify only	EDENT'S EDU highest grade	cation completed)		16e. DECEOEN	T'S USUAL Of work done of week done	CCUPATIO	ON ast of working	ng	Nationa	SINESS/INDU	STRY	-
or tor u	삘	Elementary/Secondary (0	-12)	College (1-4 or 5							Science		demy	OI
AND the hospita detached	COMPL	12 17. FATHER'S NAME (First, M	Iddin I noti	2	Program Coordinator									
≥ ≥ ≥ ×	BE CC	Frank D. Jo	nes						Shi	rley	(First, Middle, Melden E. Prout	Sumame)		
E, MARYL y be retained by lage 5 should be be notified at	10	Gerald D. J	aynes			1910 Mitc	ALLING ADDRESS (Stoped and Number or Bural Route Number, City or Town, Stelle, Zip				Code)			
TOR e 6 ma ector, p		20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify)								4	cation — ci			
ALTIN death. Pag funeral dii examiner		21. SIONATURE OF FUNERA								SS OF FACIL		T		
BAL ter death the fune oval.				shal			43	808	Suit1	and R	eral Home Rd., Suit	land,	MD 2	0746
		23. PARTA. Enter the di shock, or he	seasea, or c	complications the List only one can	t caused	the death. I	o not enter	the mo	de of dyl	ng, such s	a cerdiac or respi	ratory arre	st,	Approximate Interval Between
		IMMEDIATE CAUSE (Fin								_				Onset and Death
etely ematin		disease or condition resulting in death) a. Ourdiopalm many arrest DUE TO (OR AS A CONSEQUENCE OF):												
P.O. BOX 68760 th certificate be executed within 74 the noting physician and completely filled Hygere prior to burial, cremation, or other traumatic event, the				DUE TO	(OR AS A	CONSEQUENC	E OF): '							
executand and burnartic	CATION	Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF):												
BOX ficate be ex physician a ne prior to	¥.													
certificate ding physical dygiene pri	트	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR 4S)A CONSEQUENCE OF):												
P.O. the cent and in the cent	CERTIFI	resulting in death) LAST												
Y tra tra		DART II Other clealling				200								
	DICAL	PART II. Other significe	nt condition	a contributing to	deeth but	t not resulti	ng In the ur	nderlying	ceuse g	iven in Pa	rt I. 24a. WAS AN PERFOR			ERE AUTOPSY FINOINGS AILABLE PRIOR TO
L RECOR law requires that as been signed by lept, of Health an 23 shows any	EDIC										_ 1 _ YES 2	NO		MPLETION OF CAUSE DEATH?
111 3 " 1 8	Σ	212 722 4222 11									_		1	YES 2 NO
AL RI e faw req has been Dept. of	AN	DID TOBACCO U		RIBUTE TO CA					UNC	ERTAIN				
OF VITAL PHYSICIAN: The fav this certificate has with the State Dep xed, or Hem 23	SICI	EXAMINER?	MEDICAL	HOSPITAL:		6. PLACE OF C	OTHE	R :						
Clan	> II	1 YES 2 NO		1 Inpatient 2							Other (Specify)			
ON OF VITA DING PHYSICIAN: The After this certificate hi death with the State Is marked, or Item	ву Рн	1 Natural 5	Pending nvestigation	(Month, E	Day, Year)		TIME OF INJURY M		RK? 'ES 2	67	8d. OESCRIBE HOW II	NJURY OCCU	IREO	
ATTENDI ATTENDI CTOR: A after di 28 Is			Could not be determined	26e. PLACE C building,	of INJURY - atc. (Specif)	- At home, far	m, atreet, fect	ory, office		26	81. LOCATION (Street a City or Town, State)	and Number of	r Rural Rout	e Number,
DIV OR A DIREC DIREC Hours	2 1	29e. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowled	dge, death occ	urred at the t	lme, date	end place.	end due to	the cause(e) and man	ner as stated		
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	COMPLET	one) 2 MEDI	CAL EXAMINE	R: On the beele of a							ia, date end place, en			d manner se stated.
TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: If	O BE	29b. SIGNATURE AND TITLE	J.C.	- H	X				29c. LICE D176	O1	R	29d, DATE :	SIGNED (M	onth, Day, Year)
8)	۲	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SUJAN HONIG, MD GCOTYLTOWN UNIV MCL CT Walkington DC												
		31. DATE FILEO (Month, Day,	(bar)		R'S SIGNAT	TUREO .		JC 110)	
		JUL 2	0 1995	32. MEGISTRA	Twelse	rive-	6							



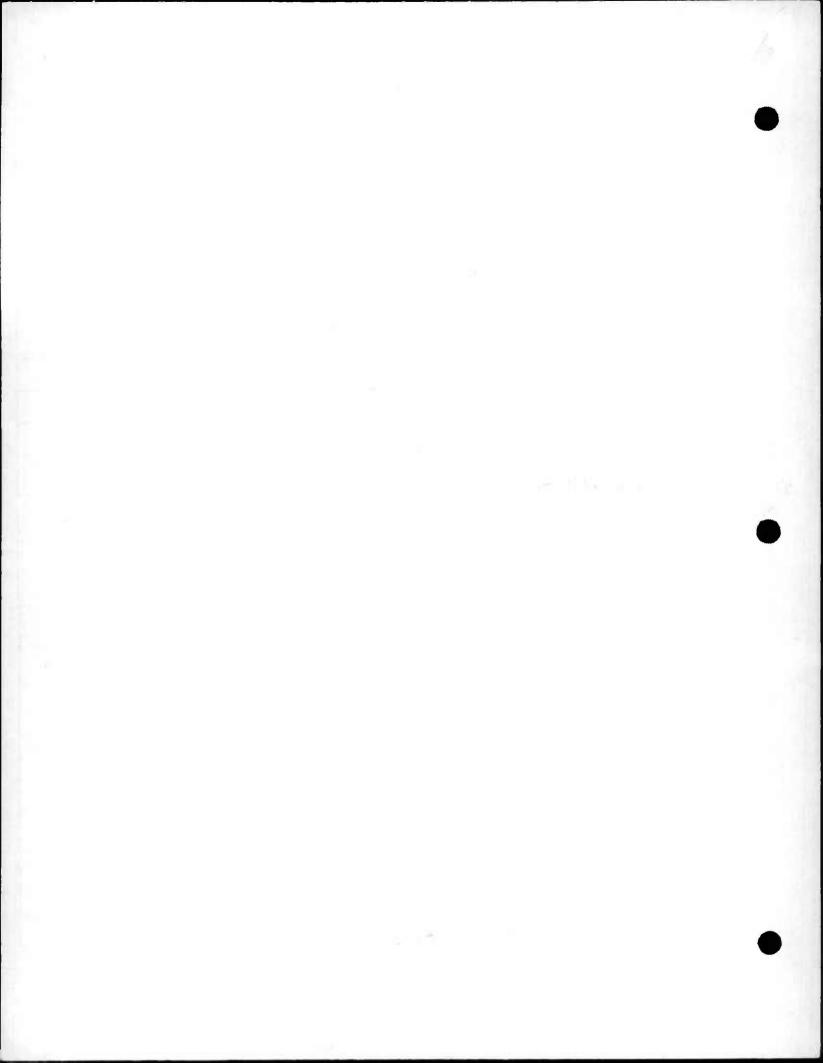
FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Elizabeth Jane Widerman July 1995 14 5:10P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Feb 11 1933 1 - M 2/XF 212-30-7110 62 New York Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATH DIRECTOR Anne Arundel Medical Center Annapolis Anne Arundel RESIDENCE OF DECEDENT 10e, STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Anne Arundel completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Annapolis YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 778 A. Fairview Avenue 21403 United States hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify:White 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY live kind of work done
Do NOT use retired.) ntary/Secondary (0-12) College (1-4 or 5+) Legal Secretary 12 Paint Industry 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) George Berggren notified at Elizabeth Curley BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Thomas E. Widerman 778 A. Fairview Avenue Annapolis, MD 21403 Pe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must Ft. Lincoln Crematory 4 Donation 5 Other (Specify) 7/17/95 Brentwood, Maryland examiner 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD medical 23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart fellure. List only ona cause on each lina. 6 interval Between **IMMEDIATE CAUSE (Final Onset and Deeth** the diseese or condition_ nemorrhage ontine 24 hus event, resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): been signed by the attending physician and com at. of Health and Mental Hygiene prior to burial, N other traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? апу 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: certificate has be the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL: DR ATTENDING PHYSICIAN: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 - Nursing Home 5 - Realdenca 8 - Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY 286. TIME OF 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED with 1 marked, 1 Natural BY 1 YES 2 NO After 2 Accident DIRECTOR: At hours after de ltem 28 is 1 3 Suicide 26a. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED 4 🔲 Homicide 29e. CERTIFIER
(Check only one)

One)

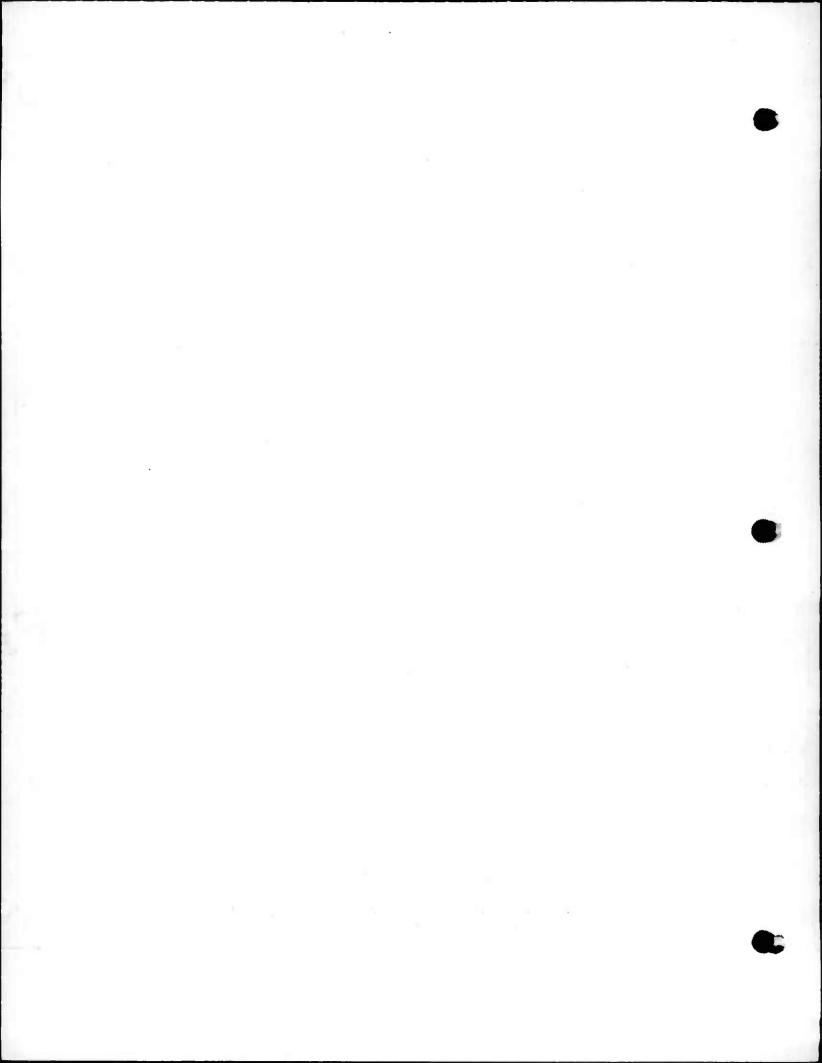
MEDICAL SYMMERS: On the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) end manner as stated. TO THE HOSPITAL D
TO THE FUNERAL D
be filed within 72 ho
IMPORTANT: If its tion, in my opinion, death occured at the time, date end place, end due to the ceuse(a) end manner es stated. 29b. SIGNATURE AND TITLE DE CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) D41816 95 MO 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED GAUSE OF DEATH (FEM 27) (Type, PHIN)
Clary les Phalis and 180 Admiral Cochrane Drive 31. DATE FILEO (Month, Day, 32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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1

		1 - STATE REGISTRAR	STATE OF MARYLAN		TMENT OF H		MENTAL HYGIEN						
		1. DECEDENT'S NAME (First, Middle, Last) ORMAND A. W	RIGHT				2. DATE OF DEATH MONTH 25	199	3. TIME OF DEATH 1:40 p. M				
Pin		214-32-6292	1 □\$2M 2 □ F 5	s. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 10/23/35		BIRTHPLACE (State or Foreign Country) ederalsburg, M				
1, 2, 3 should	TOR	9a. FACILITY NAME (If not institution, give stree Fort Howard Hos				Howard	EATH	Baltimore					
permit, Pages	DIRECTOR		Arundel	10c. CIT	y, town on locat Riva	TION		10d. INSIDE CITY LIMITS? 1 YES 2 NO					
isi	FUNERAL	3045 Perch Drive				21140		10g. CITIZEN OF WHAT COUNTRY?					
the hospital or attending physician, detached for use as the burial-transit once.	ΒY	11. MARITAL STATUS 1 Never Married 2 Narried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S FORCES? 1 □ YES 2 IF YES, GIVE WAR OR OATES 1954-1964	□ NO	13. WAS DEC	ENOENT OF HISPAI ecity Cuban, Maxica 2 XNO Specif	NIC ORIGIN? (Specify Yearn, Puarto Rican, etc.)		RACE — American Indian, Black, White, atc. SpecifyWhite				
tal or attend for use as	LETED		TION 16a mpleted) 16a College (1-4 or 5 +)	Give kind of the Do NOT us	TRY								
by the hospit be detached at once.	COMPLET	12 17. FATHER'S NAME (First, Middle, Lust) Ormond Wright		<u>Progr</u>	am Mana	16. MOTHER'S NA	ME (First, Middle, Malden		of the Navy				
retained 5 should	TO BE	Urmond Wright Ethel Adams											
ath. Page 6 may be neral director, page 9		20a. METHOD OF DISPOSITION X (X Burlel 2 Cremellon 3 Removal from State) 20b. PLACE AND DATE OF DISPOSITION (Name of competery, crematory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of competery, crematory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of competery, crematory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of competery, crematory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of competery, crematory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of competery, crematory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of competery, crematory or other place)											
4 9 2 X		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WITH TAMES OF FUNERAL HOME Federalsburg, Maryland 216											
ficate be executed within mours physician and completely filled in ne prior to burial, cremation, or reher traumatic event, the med	CATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, interval disease, or condition reaulting in desth) Coronary Artery Disease Oue to (or as a consequence of): Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events Coronary Artery Disease Oue to (or as a consequence of): Seizure Disorders Oue to (or as a consequence of): Seizure Disorders Oue to (or as a consequence of):											
at the death by the atten and Mental by injury, or	DICAL CERTIFI	PART II. Other algnificant conditions of	contributing to death but n	not reaulting	n the underlying	g cause given in	Part I. 24a. WAS AN PERFOR	IMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE				
e law requires that has been signed by Dept. of Health an	AN: MEDI	DID TOBACCO USE CONTRIE					_ /		OF DEATH? 1 YES 2 NO				
e te h	SIC	1 ☐ YES 2 🔀 NO 1	28. FIOSPITAL: [Monpatient 2 ER/Outpetien		H (Check only one) OTHER: 4 Nursing Hom	e 5 🗆 Rasidence	6 Other (Specify)						
re with the	ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 2.	28e. OATE OF INJURY (Month, Day, Year)		M 1 1	PRK? YES 2 NO	28d. OESCRIBE HOW II						
OR ATTENDING ORECTOR: After hours after death item 28 is ma	LETED	3 Suicide 6 Could not be detarmined	28a. PLACE OF INJURY — A building, atc. (Specify)				281. LOCATION (Street a City or Town, Stete)		Rurel Route Number,				
HOSPITAL FUNERAL Within 72 h	COMPLET	(Check only one) 2 MEDICAL EXAMINER: (N: To the beat of my knowledge						suse(a) and manner as stated.				
TO THE HOSPI TO THE FUNER De filed within	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEATH		M.O.	DO 9	26 Y	P (/	GNED (Month, Day, Year)				
		DR. AMABLE MENDOZA 31. DATE FILEO (Month. Day, You!) JUN 2 9 1995		ORTH P		D, FT. F	HOWARD, MAR	YLAND	21052				



DIVISION OF VITAL RECORDS, P.O. BOX 68760

											20299		
		1 - FOR STATE REGISTRAR	STATE OF I	MARYLAND C	DEPAR	TMENT O	F HEALTH AND OF DEATH	MENTAL HYGIEI					
		1. DECEOENT'S HAME (First, Middle, Last)						2. DATE OF DEATH		3.	TIME OF DEATH		
		JEAN	K.		1	WHITE		MONTH		YEAR	9:35 PM M		
		4. SOCIAL SECURITY HUMBER	5. SEX	L									
			100	6. AGE (In yrs. I		IF UNDER 1 YE	AR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	1	Country)	ACE (State or Foreign		
2		218-34-6710	1 D M 2 X F	84	YRS.			JUNE 21,	1911	WASI	HINGTON,		
2		9a. FACILITY HAME (If not institution, give s	treet and number)			9b. CITY, TO	WN OR LOCATION OF D		-	Y OF DEAT			
2	DIRECTOR	4471 WORLD FAR	M ROAD			OXI	ORD		7	TALB	TC		
ß	E E	10s. STATE 10b. COUNTY	1		10c. CIT	Y, TOWN OR L	OCATION			10	d. IHSIDE CITY		
5	5	MARYLAND	TALBOT			OXFO	ממו				LIMITS?		
Í	1 -	10e. STREET AND NUMBER	IMDOI			OAF					YES 2 XIO		
3	FUNERAL						10f. ZIP CODE		10g. CITIZI	EH OF WHA	T COUNTRY?		
8	買	4471 WORLD FAR	M ROAD				21654	Į.] [JSA			
	5	11. MARITAL STATUS	12. WAS DECEDEN			13. WAS	DECENDENT OF HISPA	NIC ORIGIN? (Specify Ye	a or Ho— 1	4. RACE -	American Indian,		
Š		1 Never Married 2 Married		MAR OR DATES	NO		s, specify Cuban, Maxico YES 2 X XD Specific			Black, W Specify:	hita, atc.		
3	ВУ	3 Widowed TOVOICE					- co 171740 opecii	·y.		specify:	WHITE		
3	ED	15. DECEDENT'S EDUCATIOH (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATIOH (Specify only highest grade completed) (She kind of work done during most of working											
3		(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.)											
2	금	1 2			TOTIO	TTEL (TIODEM TO	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	CODIT		77.077		
once.	COMPL		4	<u> EX</u>	ECUI	IVE	SECRETARY		COPAI	CH	JRCH		
	8	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S HAME (First, Middle, Maiden Surname)											
# # F	<u>m</u>	JOHN R. KIRKWOOD ANN IRENE SHERWOOD											
notified	8	19a. IHFORMAHT'S HAME (Type/Print)		1	Db. MAILING	ADDRESS (St	rest and Number or Rural	Route Number, City or Tox	vn. State. Zip C	lode)			
not	2	CHRISTIAN S.	WHITTE					, CHEVY			20915		
9		20a. METHOD OF DISPOSITION	WILLID	100000						•			
must		1X Burial 2 Cremation 3 Rame	oval from Stata	20b. PLACE cometery, cr	ANO DATE (OF DISPOSITIO	H (Name of		OCATION CI				
		4 Donation 8 Other (Specify)		OXF	'ORD	CEME'	TERY	7-13 OX	FORD	, MD	21654		
E		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. NAN	E AND ADDRESS OF FA	ACILITY					
i. examiner		-			_ =			ERAL HOMI					
Nal.		J 346 R. A					O S. HARI	RISON ST	. EA	STON	. MD		
or remova medical	- 1	23. PART i. Enter the diseases, or o	complications the	at caused the d	aath. Do r	ot anter the	mode of dying, suc	ch se cerdiec or resp	iratory arre	nt,	Approximate		
		ahock, or heart failure. I	List only one cat	use on each lin	е.						interval Between		
the		iMMEDIATE CAUSE (Final disease or condition											
I, cremation, event, the		reaulting in death) a. Cum Cum Z mm. Due TO (OR AS A CONSEQUENCE OF):											
- S			DUE TO	(OR AS A COHSE	OUEHCE O	ጉ :							
Mental Hygiene prior to burial, ijury, or other traumatic ev	Z I	Sequentially list conditions, b											
prior to buris	일	if any, leading to immediate	DUE TO	(OR AS A COHSE	OUENCE OF	7:							
prior ET	8	cause. Enter UNDERLYING	•										
giene p	Ē	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											
Hygie or ot	ERTIFICATION	resulting in death) LAST											
y, o	핑	d.											
th and Menta any injury,		PART ii. Other aignificant condition	a contributing to	death but not	resulting i	n the under	iving cause given in	Part I. 24a, WAS AF	AUTOPSY	24b. WF	RE AUTOPSY FIHDINGS		
and and	EDICAL	Abdominal Abso		piresticula		1		PERFD		AM	AILABLE PRIOR TO		
safth S 23	ō		(33 (- 1)	77-410-10	7 100	/		1 _ YES	2 Z NO		MPLETION DF CAUSE DEATH?		
shows	X									1[YES 2 NO		
3 ST		DID TOBACCO USE CONTR	RIBUTE TO CA	USE OF DEA	ATH YE	S I NO	☐ UNCERTAI	ΝП		1			
Dept 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL		28. PLA	CE OF DEAT	'H (Check only							
after death with the State Dept. of Health and 28 is marked, or item 23 shows any in	2	EXAMINER?	HOSPITAL:			OTHER:							
o the	НХ	27. MANNER OF DEATH	1 Inpatient 2				Home 5 Residence						
€ è	픕		28a. DATE OF (Month, D		28b. TIM INJ	E OF 280 URY	HJURY AT WORK?	28d. DESCRIBE HOW	INJURY OCCU	RED			
marked.	B≼	1 Netural 5 Pending 2 Accident Investigation				M 1	YES 2 HO						
Is n	0	3 Suicide 8 Could not be	28a. PLACE O	F IHJURY - At h	oma, farm, a	treet, factory,	office	281. LOCATION (Street	and Number or	Rural Route	Number,		
afte 28	핃	4 Homicide determined	building,	atc. (Specify)				City or Town, State)				
72 hours	<u> </u>												
2 hg	릴	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.											
1 H	COMPL	one) 2 MEDICAL EXAMINER	R: Dn the beals of a	xamination and/or	Investigatio	n, in my opinie	on, death occured at the	time, data and placa, a	nd dua to the	cause(a) an	d manner as stated.		
TAN		29b. SIGNATURE AND TITLE OF CERTIFIER											
be filed within	H	LAN.		40.00			29c. LICENSE NUI	MBER	29d. OATE		onth, Day, Year)		
8 ₹	0	LA STATE		(17.7			D42816		7	/11/1			
	p=0 []	30 HAME AND ADDRESS OF HERON WILL											

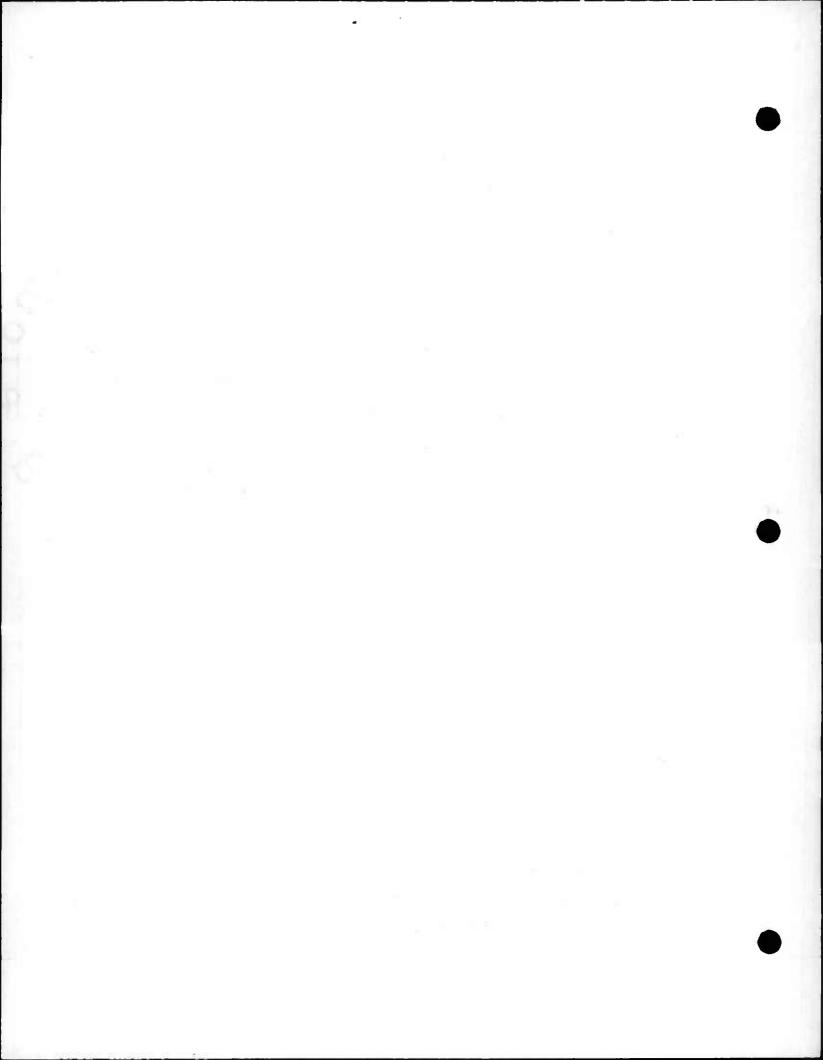
OYNE, M.D., 60

A.REGISHAR'S SIGNATURE

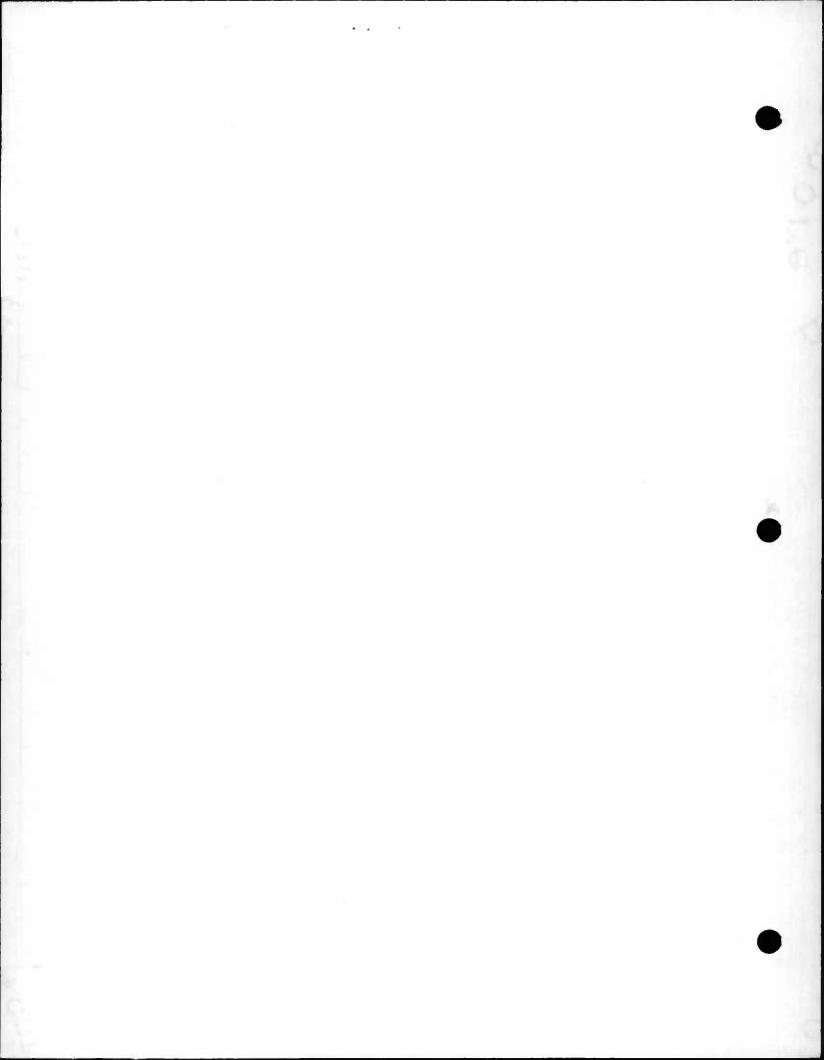
VALUE OF THE STREET RICHARD A. BURGOYNE, 607 DUTCHMAN'S LANE, EASTON, MD 21601 31. DATE FILEO (Month, Day, Year)

JUL 12 1995

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)



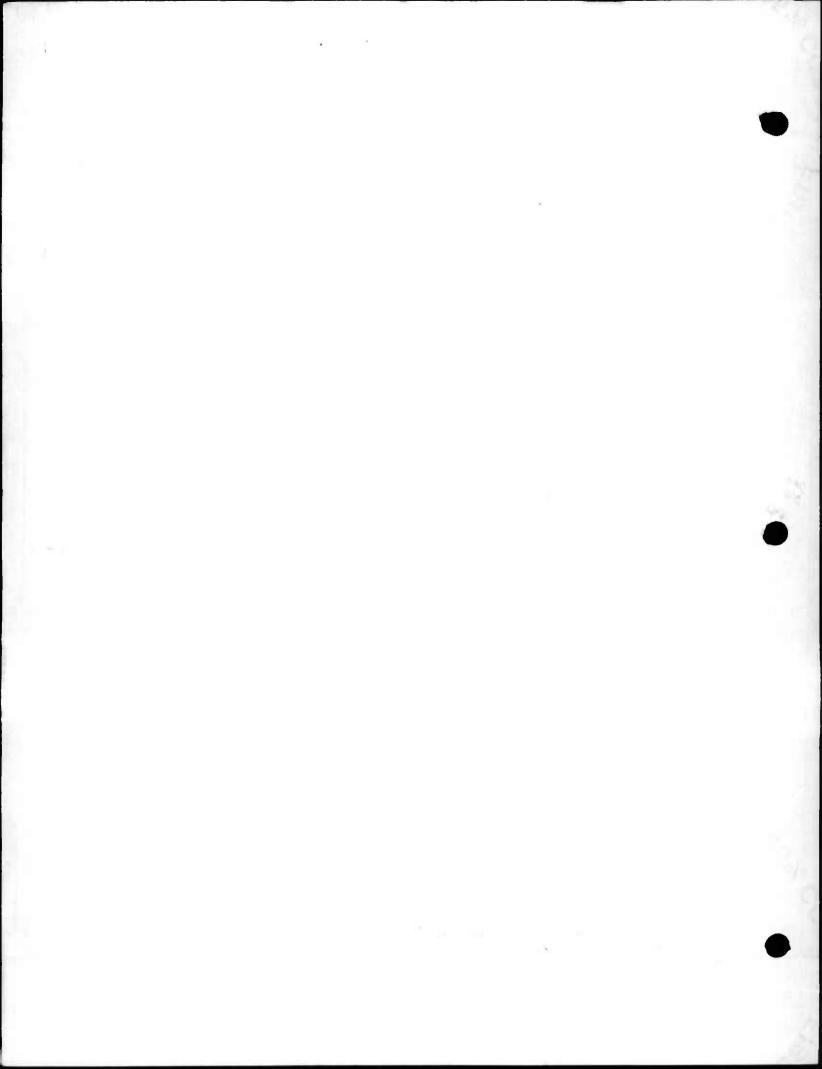
		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	RTMENT OF A	HEALTH AND I	MENTAL HYGIE REG. N				
		1. DECEDENT'S NAME (First, Middle, Last)	PAULINE W.	WILLO			2. DATE OF DEATH		YEAR	TIME OF DEATH 4:45 PM M	
29		4. SOCIAL SECURITY NUMBER 213-22-5976	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 04/15/13 BIRTHPLACE (State or Fore Country) Delaware							
2, 3 should	DIRECTOR	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH									
permit. Pages 1,		Maryland Care	19c. CIT	Y, TOWN OR LOCA	TION ederals	ourg			d. INSIDE CITY LIMITS? YES 2 KNO		
-22	FUNERAL	100. STREET AND NUMBER 2704 Lorrain		10	107. ZIP CODE 21632 10g. CITIZEN OF WH						
215-0020 attending physician. se as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	J.S. ARMED ZX RO ES	If yes, sp	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, apecify Cuban, Mexican, Puerto Rican, atc.) 1 ☐ YES 2 ☐ NO Specify: 1 ☐ YES 2 ☐ NO Specify: W						
5 5	PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	on ost of working Jurse	Nursing							
YLAND Spital by the hospital is detached to at once.	E COMPL	17. FATHER'S NAME (First, Middle, Last)	James R. Wo	ooters			IAME (First, Middle, Maiden Surname)				
E, MARYL y be retained by the age 5 should be be notified at	TO B	19a INFORMANT'S NAME (Type/Frint) Mrs. Gloria I	and Number or Rural R	Noute Number, City or To	wn, State, Zip C alsbu	rg,	MD 21632				
Fector, p		20a. METHOD OF DISPOSITION 1 M Burlel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 20b. PLACE AND DATE OF DISPOSITION (Name of cappaign), crymatory or other place) Junior Order Cemetery 7-11 Preston, Maryland									
ALT death. funer		Michael 4. Eskow Funeral Home PO Box 43, Federalsburg, MD 21632									
withing the hours affine the pletety filled in by cremation, or remover tent, the medical	CERTIFICATION	IMMEDIATE CAUSE (Finel	s. Acuts	mass	send u	I int			st,	Approximeta Interval Between Onset and Daath	
T.O. BOX 68 ath certificate be execute ttending physician and c all Hygiene prior to buria or other traumatic		Sequentially liat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST B. Cauda o Cauda Shock, DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
vinite N	MEDICAL (PART II. Other significent condition	na contributing to death but	not resulting i	in the underlying	g cause given in i		PRMED?	AVA COI OF	RE AUTOPSY FINDINGS MILABLE PRIOR TO MPLETION OF CAUSE DEATH?	
law rectast been of bept. of 23 sh		DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL			S NO	UNCERTAIN	10		1	YES 2 10	
Certificate h the State I to or item	PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/Outpetie		OTHER:	e 5 🗆 Rasidence (8 Other (Specify)				
Te state PH C	ву Рн	27. MANNED OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)		M 1 1	PRK? YES 2 NO	26d. DESCRIBE HOW INJURY OCCURED				
DIVISION DIRECTOR: After hours after death	ETED	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, s	street, factory, offic		281, LOCATION (Street City or Town, State	and Number or 9)	Rural Route	Number,	
TO THE HOSPITAL D TO THE FUNERAL DI be filed within 72 ho	COMPLET	2 MEDICAL EXAMINE	ICIAN: To the best of my knowled ER: On the basis of examination a							d manner as stated.	
TO THE P TO THE P De filed v	TO BE	29b. SIGNATURE AND TITLE OF CERTIFIE	Millow			29c. LICENSE NUM	BER 6 1 1 1	29d. DATE S	7/8	orth, Day, Year)	
		30. NAME AND ADDRESS OF PERSON WH William C. To	odd, M.D., E	Easton	Mem. H	ospital	, Easto	n, MD	216	01	
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATI	URE II							



14A

Amended #2, BJV FOR 7/18/95

	1 - STATE TAILOT CO STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
	1. DECEDENT'S NAME (First, Middle, Last)			-					2. DATE OF DEATH	2. DATE OF DEATH 3. TIME OF GEATH			
	William	Henry	Whitt:	lese	У				July 12,		5	3:45 P. M	
	ILLUSTRATION OF THE PARTY		. AGE (in yrs. last		IF UNDER 1		IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTN Counti	IPLACE (State or Foreign	
		1 M 2 D F	67	YRS.					Jan 27, 19			Virginia	
Œ	9a. FACILITY NAME (If not institution, give street				96. CITY, 1				ATN		NTY OF D	EATN	
210	9510 Martin	ignam Dri	ve		St.	Mich	nael	S		Tal	bot		
DIRECTOR	10a. STATE 10b. COUNTY			t0c. CIT	Y, TOWN OR	LOCATIO	N			10d. INSIDE CITY LIMITS?			
		bot		St.	Mich	_				1 TYES 2 X NO			
RAI	10e. STREET AND NUMBER	· 1 D				101. Z	IP CODE			10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	9510 Mart	12. WAS DECEDENT E											
BY FL	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 []	1 YES 2 XNO			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify of year, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:				s or No— 14. RACE — American Indian, Black, White, etc. Specify: White			
	15. DECEDENT'S EDUCAT	TION	16a. DEC	EDENT'S	USUAL OCC	UPATION	_	_	18b. KIND OF BUS	WESS/INC	w ISTBY		
COMPLETED	(Specify only highest grade co	College (1-4 or 5+)	(Gi/VI	e kind of a Do NOT us	vork done du	ring most o	of working	7	1000 1000	MEGG: III	oain.		
MPI	12	4	Ba	nkir	g				Finance	9			
8	17. FATNER'S NAME (First, Middle, Last)					1			NE (First, Middle, Maiden S	Surname)			
BE	William H. Whi	ttlesey							eth Davis				
2	Betty Jean Whit	tlesev							oute Number City or Town			01669	
	20a. METNOD OF DISPOSITION		20b. PLACE AN	NDDATE	DE DISPOSITI	ON /Name	of	TIVE	OATE 20c. LOC				
	1X Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)		Spring	Hil	T Cen	eter	У	7	/15/95 Ea	ston	, Ma	rvland	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Howard Con. F. Loopand Throng I. I. J. J. J. J. J. J. J. J. J. J. J. J. J.												
	Laurson Le	Jeo.	naid	_									
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate												
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) • Laurette Cause Cause Cause Interval Between Onset and Death Clause Cause												
_		DUE TO (OF	R AS A CONSEQU	JENCE OF	7:								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate												
S	cause. Enter UNDERLYING CAUSE (Disease or injury												
E	that initiated events resulting in deeth) LAST	DUE TO (OF	R AS A CONSEQU	JENCE OF	7:								
SE	d												
DICAL	PART II. Other aignificent conditions contributing to death but not resulting in the underlying causa given in Part i. 24a. WAS AN AUTOPSY PERFORMEO? AMALABLE PRIOR TO												
ä									t YES 2			COMPLETION OF CAUSE OF DEATH?	
. ME									_			1 Tes 2 No	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL					28 PLAC	F OF OF	ATN /Che	ck only one)				
SIC	EXAMINER?	IOSPITAL:	R/Outpatient 3 [DOA	OTHER:			/	3 Other (Specify)				
¥	27. MANNER OF DEATH	25a. DATE OF IN.	JURY	28b. TIMI	E OF 26	Ic. INJURY	Y AT	-derice c	28d. OESCRIBE NOW IN	JURY OCC	UREO		
ВУ	1 Natural 5 Pending 2 Accident Investigation	(MORRI, Day,	ice!)	INJ		1 YES		NO					
	3 Suicide 8 Could not be datarmined	28a. PLACE OF IN building, atc.	NJURY — At home: (Specify)	e, farm, s	treet, factory	, office			281. LOCATION (Street er. City or Town, State)	nd Number	or Rurai A	loute Number,	
9	29a. CERTIFIER												
COMPLETED	(Check only one) 2 MEDICAL EXAMINER:	N: To the best of my On the basia of axam	knowledge, deat	h occurre	d at the time	o, data and	d place, a	and due t	o the cause(s) and mann	or an state	ed.	and the second	
	29b. SIGNATURE AND TITLE OF CERTIFIER							ISE NUMI		-	-		
BE	Third of M	W	Davi	d A	. Sm	ith	1)3	SI	27	PT.	B //	Moren, Ofe Year) —	
٩	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED PAUSE OF		27) (Type.		10		2	(60/		1		
JUL 17 1995 June 11 1995													



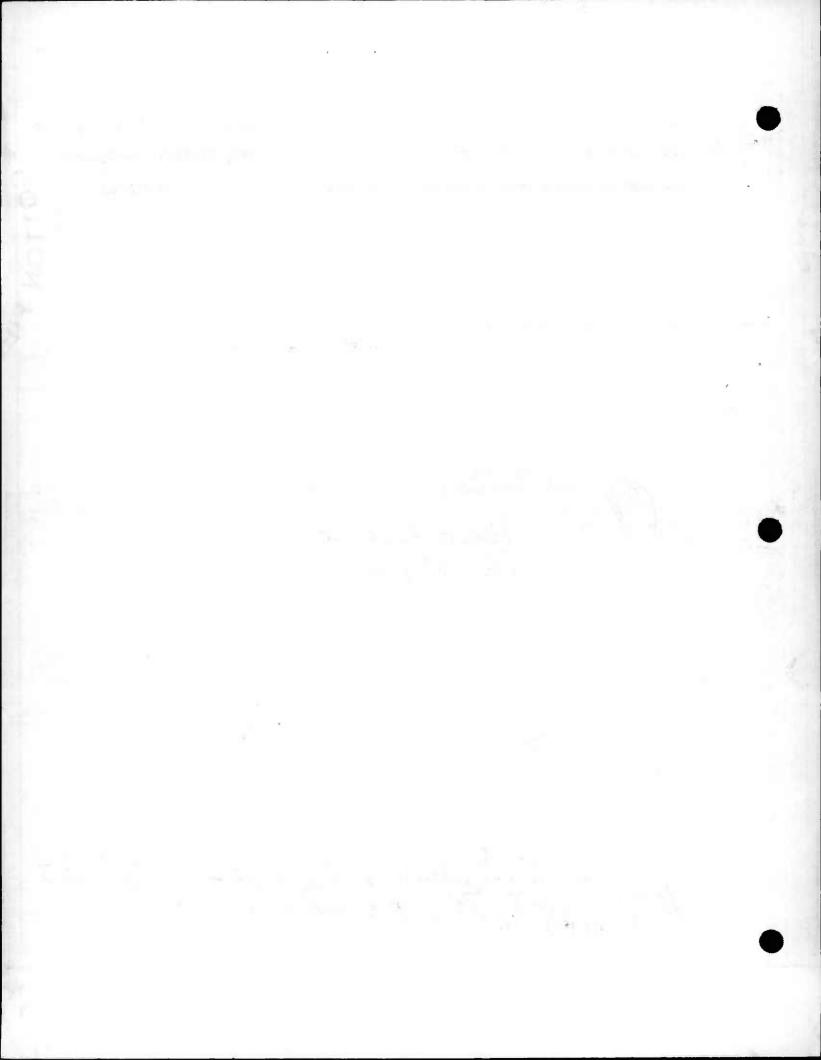
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 10 the funds after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic avent, the medical examiner must be notified at once. BALTIMORE, MARYLAND 212,15-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3.1										
	ADA Elizabeth WIRTZ			JULY 18 1995 8:1			8:15 a M				
1	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs.	last birthday)	IF UNDER 1 YEAR	7 0475 05 05			MCE (State or Foreign				
1 1	214-44-5297 1□м²№ 85	YRS.	MONTHS DAYS	HOURS MIN.	July 22, 1	ana l	Country)	land			
	9a. FACILITY NAME (If not institution, give street end number)		9h CITY TOWN	OR LOCATION OF DI	ATH		NTY OF DEAT				
Œ	GREATER BALTIMORE MEDICAL CENTE				AIN	Sc. COU	NIY OF DEAT	н			
DIRECTOR	RESIDENCE OF DECEDENT	SR	TOWSO	N		BALT	TIMORE	,			
l m	10a. STATE 10b. COUNTY	t0c. CIT	Y, TOWN OR LOC	ATION			104	d. INSIDE CITY			
=	Maryland Baltimore	Sr	parks				1	LIMITS?			
A	10a. STREET AND NUMBER				ZEN OF WHA						
EN I	14720 York Rd.	21152				S.A.					
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S.	ARMED	13. WAS D		HC ORIGIN? (Specify Yes		American Indien.				
	11. MARITAL STATUS 1 Never Merried 2 Merried FORCES? 1 YES 2	Мио	if yes,	specify Cuben, Mexico S 2 X NO Specifi	n. Puerto Rican, etc.)	or No.	Bleck, W	hite, etc.			
B	3 Wildowed 4 Divorced		101	S 2 A NO Specif	<i>f</i> :		Specify:	White			
0	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	DECEDENT'S	USUAL OCCUPAT	ION	16b. KIND OF BUS	INESS/IND					
i ii	Elementary/Secondary (0-12) College (1-4 or 5 +)	life. Do NOT us	vork done during i se retired.)	nost of working							
귤	6 A	ssemb.	ler/Pa	ckager	Medical	. Ear	uipme	ni Mfa.			
COMPLETED	17. FATNER'S NAME (First, Middle, Last)				ME (First, Middle, Maiden		- Parton	it ing.			
BE	Benjamin Franklin Ensor			Willie	Anna Ma	tild	la Nas	sh			
	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street		Route Number, City or Town						
2	Ruth E. Wirtz				parks, M						
	20s. METNOD OF DISPOSITION 1. Burlai 2 Cremation 3 Removal from State semetary.		OF DISPOSITION (leme of	DATE 200 LOV	CATION	Cibi or Town	Ctoto			
	1.0 Burlai 2 Cremation 3 Removal trom State semetary,	crematory or of	M. Cem	atom. J	1995 Sp	arke	MID.	State			
1 1	21. SIGNATURE OF PUNERAL SERVICE LICENSEE /	op u.	22 NAME								
			J.J.	Hartens	tein Mort	uarv	. Inc				
\sqcup	A. Harlenslein		24	Second S	tein Mort	reed	om, P	A 17349			
1 1	23. PART L'Enter the diseasee, or complicatione that caused the shock or heart feliure. List only one cause on each li	death. Do n	ot enter the m	ode of dying, auc	h as cerdiac or respi	retory arm	est,	Approximeta			
	VIMMEDIATE CAUSE (Final		1					Intervei Between Onset end Death			
22	disease or condition resulting in death)	- Fa	elur	e							
	DUE TO (OR AS A CONS	SEQUENCE OF	D: 1								
z	disease or condition resulting in death) e										
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):										
8	cause. Enter UNDERLYING										
드	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONS	SEQUENCE OF	7:								
토	resulting in death) LAST										
	PART II ON										
EDICAL	PART II. Other significent conditione contributing to deeth but no	t resuiting i	n the underlyi	ng ceuse given in	Part i. 24a. WAS AN / PERFORI			RE AUTOPSY FINDINGS			
음					1 YES 2		COI	MPLETION OF CAUSE DEATH?			
Æ								YES 2 NO			
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE	ATH YE	S I NO [UNCERTAIN	<u></u>						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PL		N (Check only one								
Sign	1 YES 2 NO 1 Department 2 ER/Outpatient	3 DOA	OTHER:	me 5 Residence	8 Other (Specify)						
ξI	27. MANNER OF DEATH 280. DATE OF INJURY	28b. TIME	OF 28c. IN	JURY AT	28d. DESCRIBE NOW IN	JURY OCC	URED				
	1 Natural 5 Pending (Month, Day, Year)	INJ		ORK? YES 2 NO							
BY	3 Suicide 28s. PLACE OF INJURY — At	home, farm, a			281. LOCATION (Street at	nd Number	or Bural Boute	Alumbar			
日日	8 Could not be determined building, atc. (Specify)				City or Town, State)		or rigidir riodio	Humbol,			
W	290. CERTIFIER										
를	(Check only one)										
COMPLET	one) 2 MEDICAL EXAMINER: On the basis of axamination and/o	or investigation	n, in my opinion,	death occured at the	time, date end placa, and	due to the	cause(s) end	i manner ee stated.			
ш	29b, SIGNATURE AND TITLE OF CERTIFIER	1 -	11.1	29c LICENSE NUM	MEN	29d. DATE	SIGNED (NO.	nth, Day fings			
TO B	1700EE 0-1-10H	un	-UVV	154	622		7/1	8195			
F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DESTH (IT	EM #7) (FYDA	Print)	//	2 / /)	-/-				
	16540 GOVE KM	TIC	reso	WML	12111	!					
	31 DATE FILER (MOITH, Day, Your) 32. REGISTRAR'S SIGNATURE	2 1 11	17								
	. Aud 02 1995 Juli Ducker M	artall	V								
	El el										



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	things hours after death. Page 6 may be retained by the hospital or
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X 68760	executed within 24 ho
OX 68760	be executed within 4 ho
80X 68760	ate be executed within 4 ho
BOX 68760	ficate be executed within 24 ho
O. BOX 68760	ertificate be executed within 4 ho
.O. BOX 68760	certificate be executed within 4 ho
P.O. BOX 68760	ath certificate be executed within 24 ho
S, P.O. BOX 68760	death certificate be executed within 24 ho
DS, P.O. BOX 68760	he death certificate be executed within 4 ho
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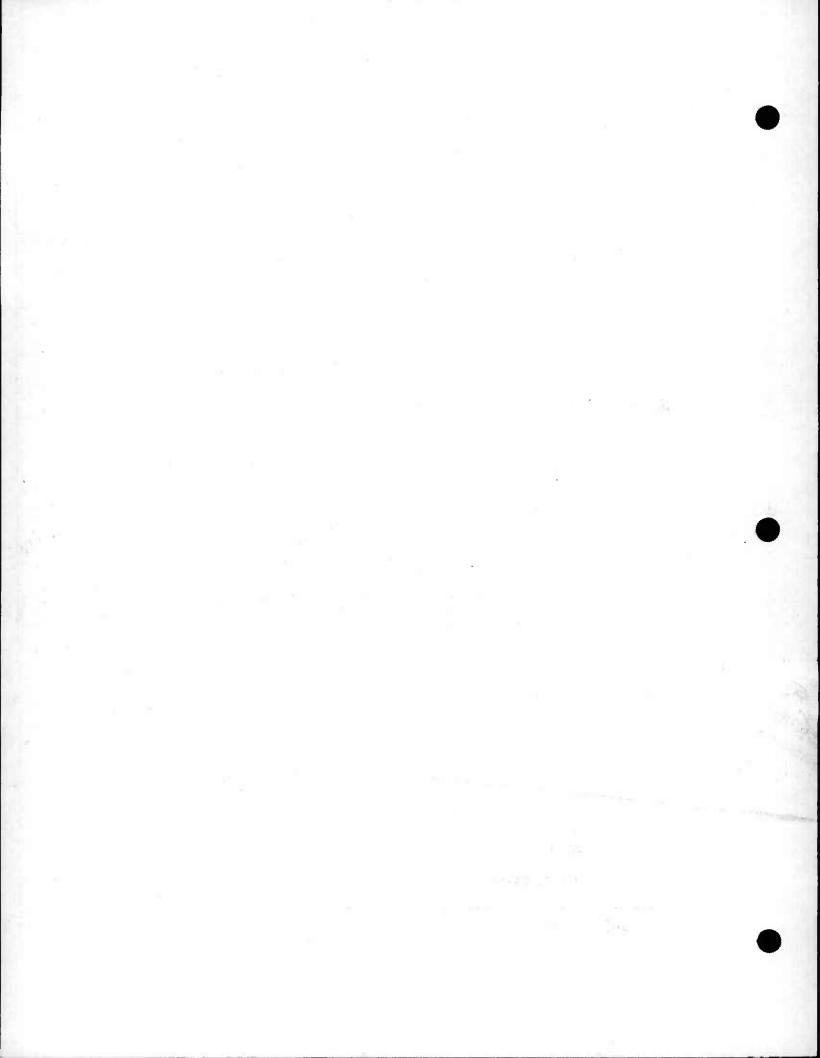
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permit. Pages 1, 2, 3 should as the burial-transit attending physician. use ğ detached 1 once. page 5 should be notified at must be director, examiner funeral (In by the for removal. the medical completely filled in rial, cremation, or r other traumatic event, signed by the attending physician and cor Health and Mental Hygiene prior to burial, 6 shows any injury, has been : Dept. of t 23 Item OR ATTENDING PHYSICIAN: The this certificate h 0 marked, DIRECTOR: After the hours after death v 59 28 FUNERAL DIRECT within 72 hours a

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 9:46 Elizabeth MARCHERITE WISE JULY 1 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year)
NOV • 5, IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 217-28-5989 Md . 1 M 2 X F 63 DAYS HOURS Nov. YRS 1931 9e. FACILITY NAME (If not institution, give etreet end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH DIRECTOR Washington Adventist Hospital Takoma Park Prince Georges RESIDENCE OF DECEDENT 10a. STATE 16c. CITY, TOWN OR LOCATION 10b. COUNT 10d. INSIDE CITY Md. Frederick Middletown 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10g, CITIZEN OF WHAT COUNTRY? 407 W. Main St. 21769 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR OATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2XXMarried BY 1 YES AND NO Specify: 3 Widowed 4 Divorced White COMPLETED 18e. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEOENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hi Elementary/Secondary (0-12) College (1-4 or 5+) 12 cook public schools 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Edgar M. Welty Laura Baker BE 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. INFORMANT'S NAME (Type/Print) 2 Merhle C. Wise 407 W. Main St., Middletown, Md. 21769 20a. METHOO OF DISPOSITION
1 M Burlei 2 Cremation 3 Removal from State 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Pleasant View Ceemtery 4 Donetlon 6 Other (Specify) 7/19 Burkittsville. Md. 21. SIGNATUR OF FUNERAL SERVICENSEE 22. NAME AND ADDRESS OF FACILITY Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart feliure. List only one ceuse on each line. Approximata Interval Betwe IMMEDIATE CAUSE (Final Onset and Death disesse or condition Oday resulting in death) MEDICAL CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CONSFOUENC that initiated events reaulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE 1 | YES 2 4 NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\overline{\ PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: 1 YES 2 NO OTHER: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 26e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF OEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 4 Homicide

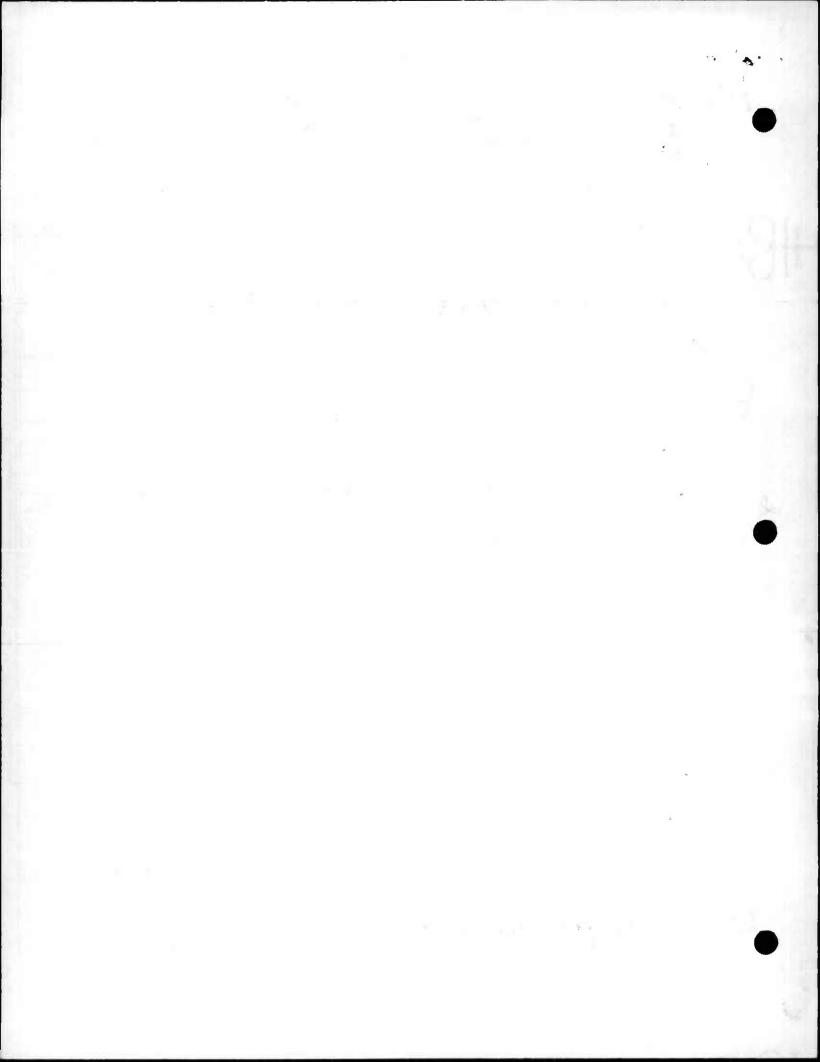
29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. 2 MEDICAL EXAM On the basis of exemination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(e) end manner es stated. 29b. SIGNATURE AND TITLE OF 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 995 CAUSE OF DEATH (ITEM 27) (Type, Print) 36. NAME AND ADDRESS OF PERSO MJum This Studen Restall



1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Tiney Richard 19:58 Wotring М une 16 1995 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTN (Month, Day, Year) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS MIN 233-44-6530 XX M 2 - F 65 Apri1 1930 WV Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Garrett County Memorial Hospital 0akland Garrett RESIDENCE OF DECEDENT 10a. STATE 106 COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY WV. Preston Aurora permit. 1 YES 2 TNO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? page 5 should be detached for use as the bunial-transit HC 82 Box 42 26705 BALTIMORE, MARYLAND CITY.

hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 12 YES 2 NO 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify: Widowed 4 Divorced Discharged Nov. 1959 White COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complete 18a. OECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ndary (0-12) College (1-4 or 5 +) 12 Farmer Agriculture 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Sumame) 듉 David Isaac Wotring BE Lela Elizabeth Shaffer notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Josephine Lambert Box 350 Aurora 90 METNOD OF DISPOSITION 20a. METNOD OF DISPOSITION
1 M Burlal 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must DATE netery, crematory or other place Donation 5 Other (Specify) Cemetery 6/19/9
22. NAME AND ADDRESS OF FACILITY Aurora Aurora, WV. 6/19/95 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Hinkle Funeral Home, Inc. B.O. Box 186 Davis, WV. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, filled in by Approximate ahock, or heart feilure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Finel Onset and Deeth and completely fille burial, cremation, the disease or condition _____ Sudden cardiac death 30 minutes event, BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): 2 attending physician a ental Hygiene prior to if any, leading to immediate that the death certificate be cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): DIVISION OF VITAL RECORDS, P.O. thet initieted events resulting in death) LAST 0 y the at. ≺ Mental F PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE been signed by th shows any Type II diabetes mellitus 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN CIAN: has b ₩. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only o HOSPITAL OR ATTENDING PHYSICIAN: The this certificate h HOSPITAL:
1 | Inputient 2XXER/Oulputient 3 | DOA OTHER: 1 YES 2 NO PHYSI 4 Nursing Home 5 Residence 8 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED marked. 1 X Natural 5 Pending Investigation 1 YES 2 NO After 1 death BY 2 Accident 28a. PLACE OF INJURY — At home, larm, strael, factory, offica building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be DIRECTOR: hours after 28 4 Homicide determined 29a. CERTIFIER 1 XCERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. FUNERAL within 72 h 2 _ MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: I 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D33464 9 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Coughlin M.D. P.O. Box 8 Eglon, wv 26716 31. DATE FILED (Month, Day, Year) 82. REGISTRAB'S SIGNATURE JUL 8 1 1995



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within property. The funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICAI E	F DEAT	Н	REG. NO.				
1	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH			3. TIME OF DEATH	
N.	Douglas Robert						07 17 95				
1 1	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)		AR IF UNDER 2			. /		1630 ₩	
1 3	A CONTRACTOR OF THE PARTY OF TH	1 🕅 M 2 🗆 F		IF UNDER 1 YE		MIN.	7. DATE OF BIRTH (Month, Day, Year)		S. BIRTHPI Country)	LACE (State or Foreign	
1 1	219-02-8923	16 YRS.				07-19-7					
1 4	9a. FACILITY NAME (If not institution, give s	street end number)		9b. CITY, TO	WN OR LOCATIO	N OF DEA			TY OF DE		
<u>د</u>	24752 Porter Mill	Pond		II a la sa a							
DIRECTOR	RESIDENCE OF DECEDENT	Road		Hebro	n			Wico	<u>omico</u>		
<u>ш</u>	10a. STATE 10b. COUNT	Υ	10c, CIT	Y, TOWN OR L	OCATION				1	10d. INSIDE CITY	
<u>e</u>	Manufland 167							LIMITS?			
	Maryland Wico	MICO	The	ebron				1 🗆 YES 2 🙀 NO			
₹	10e. STREET AND NUMBER			101. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	24572 Porter Mil	1 Road		21830			U.S.				
3	11. MARITAL STATUS	12. WAS DECEDENT EVER I	IN U.S. ARMED	13. WAS	-1000		C ORIGIN? (Specify Yes		14 BACE -	- American Indien,	
	1 X Never Married 2 Married	FORCES? 1 YES	2 X NO	If yes	, specify Cuben.	, Mexican,	Puarto Ricen, etc.)	0.110	Black,	White, etc.	
₩	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	DATES	1 🗆	YES 2 X NO	Specify:			Specify.		
۵	15. DECEDENT'S EDU	CATION	18e. DECEDENT'S				The State of State of			White	
#	(Specify only highest grade	completed)	(Give kind of	work done durin	MITON most of working	7	16b. KIND OF BUS	SINESS/IND	USTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u								
COMPLETED	10		Produce	Clerk			Jack's	Produ	Jce		
Ö	17. FATHER'S NAME (First, Middle, Last)				18. MOTH	ER'S NAM	E (First, Middle, Malden	Sumame)			
ш	Robert Eugene Wal	lton			Napo	cv Ti	urkington				
0	19e, INFORMANT'S NAME (Type/Print)		10h MAII INC	ADDRESS (Co.			oute Number, City or Tow		2 (1)		
임		Ddi									
	Nancy Turkington	brady	24/52	Porte	r Mill	Road	d, Hebron,	Md.	2183	30	
	20e. METHOD OF DISPOSITION 1 M Burial 2 □ Cremetion 3 □ Ram	comi from State	b. PLACE AND DATE	OF DISPOSITIO	N (Name of		DATE 20c. LO	CATION — C	Ity or Tow	n, State	
	4 Donation 5 Other (Specify)	St	netery, crematory or o	Cemet	erv		7/20 Pri	inces	e Ann	ne Md	
1	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			E AND ADDRESS			LIICES	3 AIII	ic, iiu.	
		11		HIN	MAN FUI	NERA	L HOME				
	James).	MOU MOO	0295				. MD. 2185	53			
	23. PART i. Enter the diseases, or	complications that cause	d the death. Do	not enter the	mode of dvin	na. such	es cardiec pr respi	ratory srre	est.	Approximate	
	shock, or heert feilure.	Liet only Dne ceuse Dn	ech ilne.			3.			,	interval Between	
	IMMEDIATE CAUSE (Final disease or condition									Onset and Death	
	resulting in death)	. Gunshot wo									
	DUE TO (OR AS A CONSEQUENCE OF):										
z		self-inflicted									
CERTIFICATION	Sequentially liet conditions, if any, leading to immediate		A CONSEQUENCE O	F):							
3	cause. Enter UNDERLYING										
표	CAUSE (Disesse or Injury thet Initiated events	DUE TO (OR AS /	A CONSEQUENCE O	F):					_	-	
투	resulting in death) LAST			·						į	
真		d								i	
	PART II. Other significent condition	ne contributing to death i	but not recuiting	In the under	ving ceuse al	lven in P	art i. 24e, WAS AN	ALITOPSV	24b V	VERE AUTOPSY FINDINGS	
EDICAL				in the disco	yang couse gi		PERFOR		1	WAILABLE PRIOR TO	
ă							1 🗀 YES 2	X NO		COMPLETION OF CAUSE OF DEATH?	
									1 1	YES 2 NO	
2	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF	DEATH	YES []	NO					
A	25. WAS CASE REFERRED TO MEDICAL				S. PLACE OF DE						
PHYSICIAN	EXAMINER?	HOSPITAL:		OTHER:							
\ X I	1X YES 2 NO	1 Inpetient 2 ER/Out				sidence 6	Other (Specify)				
표	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c	INJURY AT WORK?		28d. DEŞCRIBE HOW II	NJURY OCC	URED		
BY	t Naturel 5 Pending 2 Accident Investigation	07-17-95	140	M 4	YES 2 😿	NO	Self-infl:	icted			
	3 X Suicide 8 Could not be	28e. PLACE OF INJURY	Y — At home, farm.		office		281. LOCATION (Street a		or Rural Ro	ute Number,	
9	4 Homicide determined	Home-24752	Portor	Mill D	5.00	T-	City or Town, Stete)				
Ξi.	en ormanico	110me-24732	FOLLEL	MILLI K	Jau	1.	lebron, MD				
7		ICIAN: To the best of my know	viedge, death occurr	ed at the time,	date end placa,	and due to	o the ceuse(e) and men	ner ee state	d.		
COMPLET	one) 2 MEDICAL EXAMINE	R: On the beals of examination	on end/or investigation	on, in my opinie	n, desth occure	d at the ti	me, date end piece, en	d due to the	cause(e)	end mennar as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIE										
핆	A SECTION OF THE STATE OF SECTION OF THE SECTION OF	~ · · · ·			29c. LICEN		SER .			Month, Day, Year)	
6	John G	> Julkele	I F.M.Ju	M.E.	D03!	599		07 -	-17-9	95	
-	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type	, Print)							
	John T. Bulkeley,	M.D., 108 P	ine Bluf	f Road	, Salie	shire	. Marulan	d. 21	201		
	31. DATE FILED (Month, Day, Year)	132. REGISTRANS SIGN	MATURE	000		VUL.Y	, HOLVION	47 41			
	JUL 2 1 1995 Sel	A STANDARDE MANAGE	-								
		1									

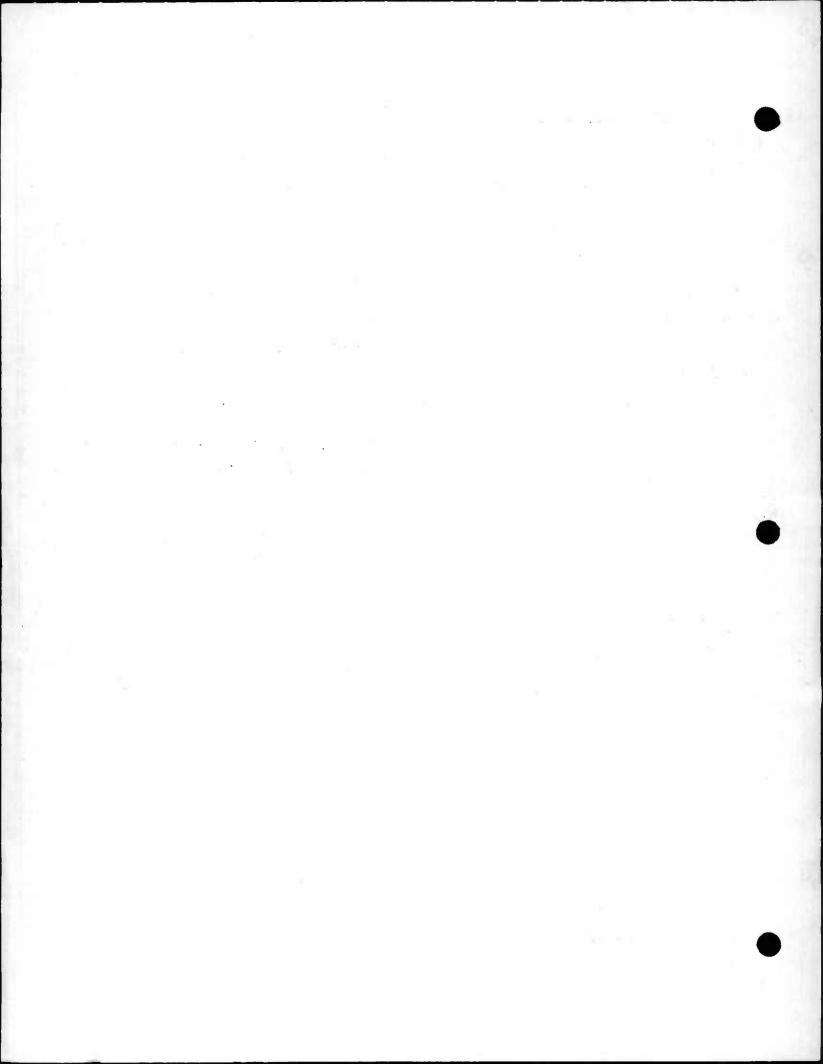
the first of

DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-ze hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	TO THE	TO THE 1 be filed v	IMPORT

permit. Pages 1, 2, 3 should

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RHE	CALE	DEA	I H	F	REG. NO.			
	Alice Virginia ZELLER MONTH DAY YEAR										3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 214-09-4806		SE (In yrs. last t	birthday)	IF UNDER 1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF (Month, D) Feb. 2	BIRTH by. Your)	<u> </u>	6. BIRTHP	LACE (State or Foreign
	9s. FACILITY NAME (If not institution, give s			YRS.					1,190	_	Mary	
Œ	Washington County				9b. CITY, TOWN						TY OF DE	
유	RESIDENCE OF DECEDENT	HOSPICAL				Hage	ISLO	MIT.		wa	shin	gcon
FUNERAL DIRECTOR	10a STATE 10b COUNTY										10d. INSIDE CITY	
		ngton			Hage	stow	n			-		LIMITS?
	10e. STREET AND NUMBER			101. ZIP CODE					10g. CITIZEN OF WHAT COUNTS			
Ä	319 Radcliffe Ave			21740					USA			
<u> </u>	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVE FORCES? 1 Y	R IN U.S. ARMI	ED	13. WAS OF	CENDENT (OF HISPAN	NC ORIGIN? (S	pecify Yes o	or No-	14. RACE - Black.	- American Indian, Whits, stc.
Æ	3 Wildowed 4 Divorced	IF YES, GIVE WAR OF	DATES			S 2 X NO			,, (10.)		Specify:	
	15. DECEOENT'S EDUC	CATION	16s. DECE	EOENT'S	USUAL OCCUPAT	ION	_	18h KII	ID OF BUSI	MESS/IND		irce
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give	kind of w	ork done during n	ost of world	ing	Tou. rai	D OF BOSI	NESS/IND	Jaini	
립	4	0			laundi	y wo	rker		laun	dry		
ğ	17. FATHER'S NAME (First, Middle, Last)		*			_		ME (First, Midd				
BE	John Redmond							Cave				
5	19s. INFORMANT'S NAME (Type/Print)		19b. I	MAILINO	ADDRESS (Street	and Numbe	r or Rural F	Route Number,	City or Town,	State, Zip	Code)	
F	Alice V. Zeller		(p	re-a	rranger	ents)	319	9 Radc	liffe	Ave	.,Has	gerstown,Md
	20a. METHOD OF DISPOSITION 1 D Burlet 2 Cremation 3 Remo	ovel from State	20b. PLACE AN	DATEO	FDISPOSITION (iame of		OATE	20c. LOC/	ATION C	City or Town	n, Stats
	4 Donation 5 Other (Specify)	+	Rose	Hill	Cemete	ry	7-27	7-95	Hage	rsto	wn, l	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	~~~	1		22. NAME			AL HOM	r.			
	Dadli	lunn	uk	_					_	etou	n Md	217/0
	23. PART I. Enter the diseases, Dr complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate											
	shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Fine)											
	disease or condition resulting in death)	I have if autothic endothernel install							-			
	resulting in destri)	DUE TO (OR A	S A CONSEOU	ENCE OF	i dil	1 6	7 /	1.6001	const		1447/	unsell
z		- Chillie	reolei	efte	Ment	de	wen					mary
을 II	Sequentially list conditions, if any, leading to immediate	DUE TO (OR A	S A CONSEOU	ENCE OF):							years
CERTIFICATION	Cause, Enter UNDERLYING CAUSE (Disease or Injury											
E I	that initiated events resulting in death) LAST	DUE TO (OR A	S A CONSEQU	ENCE OF):							
E		l										
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS											
EDICAL	Quinter Variation Sinesa with respect of the PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE											
	Fort Brikette	melliton,	Ku	a le	asla	/		_ ''	1150 2 12	21. NO		F DEATH?
2	DID TOBACCO USE CONTR	RIBUTE TO CAUSE	OF DEATH	H YES	S D NO	TUNC	ERTAIN				'	YES 2 NO
Ž.	25. WAS CASE REFERRED TO MEDICAL				(Check only one							
Sic	EXAMINER?	HOSPITAL:	utpetient 3 🗆		OTHER: 4 - Nursing Ho	ne 5 🗆 Ra	sidence (8 Other (Sc	ecify)			
PHYSICIAN:	27, MANNER OF DEATH	28s. DATE OF INJUR (Month, Day, Year	Y :	28b. TIME	OF 28c. th	JURY AT		28d. DESCRI		IURY OCC	URED	
BY	1 Netural 5 Pending 2 Accident Investigation	(MOINI, Day, Isa	'	INJU		YES 2	□ NO					
	3 Suicide 8 Could not be	28s. PLACE OF INJU- building, atc. (S	RY — At home	, farm, st	reet, factory, offi	28		28f. LOCATIO	N (Street and	d Number o	or Rural Rov	ite Number,
E L	4 Homicide determined		,					City or io	wii, State)			
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my kn	owledge, death	OCCUITED	at the time, dat	and place	, and dua	to the cause(s) and manne	er as state	d.	
S O	29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.											
Ü I	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)											
ω	5 1	46 Sthewood	1)		n	110	207		> 7	7/10	COCCO
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	DEATH (ITEM 2	27) (Type, I	Print)		010	7/_		· ·	14	4)
	man :	/	ETNA		Ha6	mo	. 21	740				
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SI		170 /	LING	1110	6/1	1 40				
	JUL 2 5 1995 A	the Davidsont	arball									



TO BE COMPLETED BY FUNERAL DIRECTOR

15	Ξ,	-	9
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a sun	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or r	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the me
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1	FOR STATE REGISTRAR	STATE OF	MARYLAND / DEPAR				
)	1. DECEDENT'S NAME (First, Middle, Leet) ESTHER C. ALPHER						
r	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER	R 1 YEAR	IF UNDE	R 24 H
		- 300-	0.5	MONTHS	DAYS	HOUSE	1 14

ND MENTAL HYGIENE REG. NO.

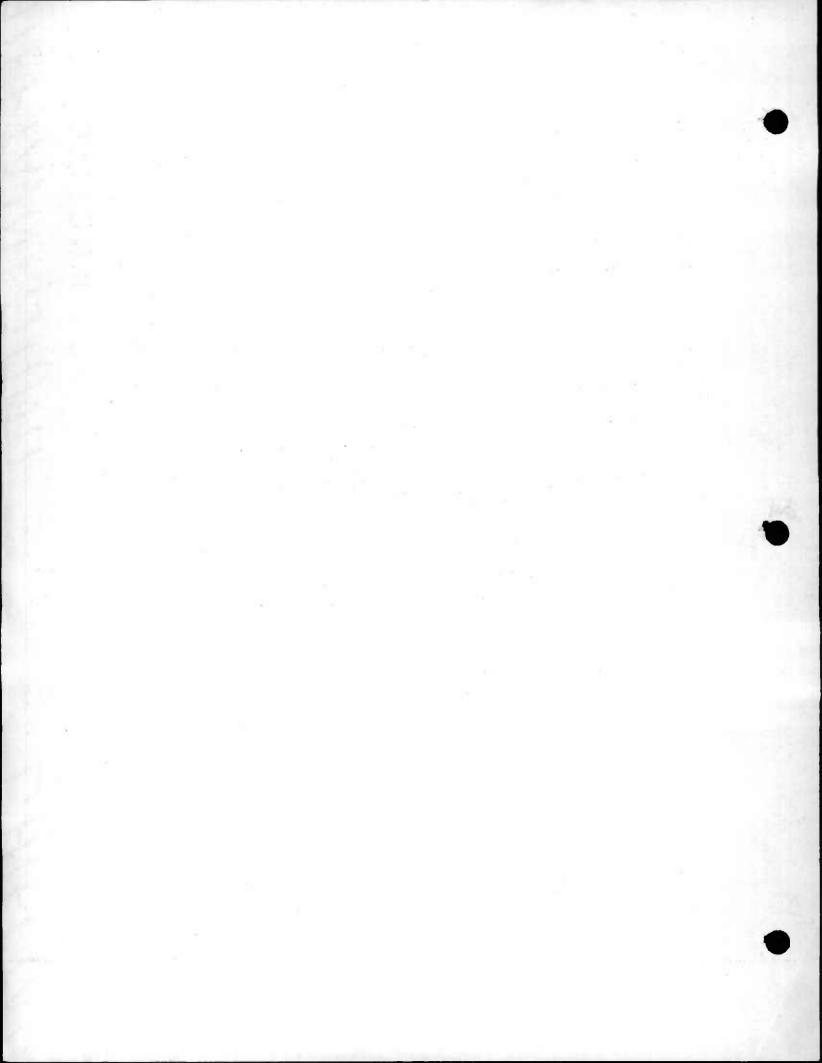
1. DECEDENT'S NAME (FI		•							2. DATE C	F DEATN	DAY	YEAR	3. TIME OF	DEATH
ESTHER C.	ALPHE	R							JULY	14,	1995	TEAN	9:40	A
4. SOCIAL SECURITY NU	MBER	5. SEX	6. AGE (In yrs. Ins	t birthday)	IF UNDER			R 24 HRS.	7. DATE 0	F BIRTN		a. BIRTH	HPLACE (State	or Foreign
216-40-88	91	1 M 2X F	85	YRS.	MONTHS	DAYS	HOURS	MIN.	APR.	23,	1910	MIS	SOURI	
9e. FACILITY NAME (If no	institution, give	street and number)			9b. CITY	TOWN (OR LOCAT	ION OF D			_	NTY OF D		
15020 WEST	OLM CO	OURT			STI	VER	SPR	TNG			MOI	NTGO	MEDV	
RESIDENCE OF DI	10b. COUN			T							1 110			
	30,000			10c. CIT	ry, town o	OR LOCA	TION						10d. INSIDE	CITY
MARYLAND		GOMERY		SIL	VER_S	_							1 YES	Δ
10e. STREET AND NUMBE						10	f. ZIP COI	DE			10g. CIT	IZEN OF	WHAT COUNT	RY?
15020 WESTE	IOLM CO	OURT				2	0906				UNI	red :	STATES	
11. MARITAL STATUS		12. WAS DECEDED	NT EVER IN U.S. AR		13.	WAS DEC	CENDENT	OF NISPA	NIC ORIGIN?	(Specify Ye	s or No-	14. RACI	E - American k, White, atc.	Indian,
1 Never Married 2 3 Wildowed 4 D			MAR OR DATES					Speci		ceri, erc.)		Spec		
15. D	ECEDENT'S EC	DUCATION			USUAL O				16b.	KIND OF BU	JSINESS/INI	DUSTRY		
Elementary/Secondary	only highest gra	College (1-4 or 8	+)	Do NOT u			ast of work	ding						
12	("	FUND	RAISE	ER			CH	ARITA	LBE (ORGAI	NIZATI	ONS
17. FATHER'S NAME (First,	Middle, Last)						16. MO	THER'S N	AME (First, Mi	iddle. Maide	n Sumame)			
SIMON ROSE	MREDC										,			
19a, INFORMANT'S NAME			19	h MAILING	ADDRESS	2 /Street			Route Number		um Ctute 76	n Codel		
		HOMMED)												
BERYL KRAM			20b. PLACE	6 MC/	ALPIN	E C	OURT	SIL	VER S					
207. METHOD OF DISPOS 1 Durtel 2 Creme		moval from State	other pl	ace) TIII	DEAN	MEM	ORTA	T. CA	RDEN		EY.			
4 Donation 5 Ott		introce .			-									
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Sol	se 7	5/4	1 1 1 1		- 11	70	ROCK	VILL	E PIK	E, RC	CKVII	LE.	MD 20	852
23. PART I. Enter tha	diseases, o	r complications the	at caused the de	eth. Do	not enter	the mo	ode of d	ving, su	ch as cardi	ac or real	piratory ar	rest.	Appr	oximate
ahock, or	heart fallure	e. List only one ca	use on each line	h.					Cir. day - both				intary	ral Betwee
iMMEDIATE CAUSE (I	Finei	Cont	. and	25	0.		1.	100	1.01	Con	./		Unse	t and Daat
reaulting in death)	\rightarrow	a. Cucan	acuro	7	Leur	un	4 10	40	venue	(acc	cerny	roper	3 14	rucch
		A DOE IC	O (OR AS A CONSE	VC	141.1.	T	4						1	kent
Sequentially ilst con-	ditione,	" Segri	YOR AS A SOME	OLIENIOE O	- uu	40							-	ece sol !
if any, leading to imp	nediata =	Con	O (OR AS A CONSE	DUENCE O	LP	/	1.	0	0				4	1/ 1000
ceuse. Enter UNDER! CAUSE (Disease or in			Off AS A CONSE	44	rug	6	M		_					12 year
that initiated events resulting in death) L	LST.	DUE TO	(OR AS A CONSE	QUENCE O	NF):									
resulting in death, L		d												
PART II. Other signifi	cant conditi	one contributing to	death but not	resuiting	in the ur	nderlyin	a cause	given ir	Part i.	24a WAS A	N AUTOPSY	241	b. WERE AUTO	PSV FINDING
	211211	res Q.	helian.	1 21	-12.	-00	•			PERFO	PIMED?		AVAILABLE F	PRIOR TO
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eri	or ru	yourse	Infa	rete	in .	188	1							
25. WAS CASE REFERRED EXAMINER?	TO MEDICAL	HOSPITAL:	U				LACE OF	DEATH (C	heck only one)				
1 TYES 2 NO			☐ ER/Outpetlant 3	DOA	4 Nur		ne 5 12 1	Residence	8 🗆 Other	(Specify)				
27. MANNER OF DEATH		28s. DATE O	F INJURY Day, Year)	28b. TIR	ME OF JURY		JURY AT		28d. DE\$6	CRIBE HOW	INJURY OC	CURED		
	Pending investigation		Dely, rear)	"	M		YES 2	□ NO						
2 Accident 3 Suicide	Could not b	28e. PLACE	OF INJURY — At he	ome, farm,	street, faci	tory, offic	ce		281. LOCA	TION (Street	t and Numbe	r or Rural	Route Number,	
4 Homicide	determined	building	, atc. (Specify)						City o	r Town, Stat	9)			
29a. CERTIFIER			les parentes a		G Common	UNIOVO HOLE			SITES IN		vs Egrock	-17		
(Check only		/SICIAN: To the best o												
2 M	EDICAL EXAMI	NER: On the basis of	examination and/or	investigati	on, in my o	opinion,	death occ	ured at th	e Ilme, data	end place, i	and due to I	ha cause(a) and manne	r se stated.
296. SIGNATURE AND TIT	LE OF CERTIF	TER					29c. LI	CENSE NU	JMBER				D (Month, Day,	Year)
witer	à m	7					0	1360	918		1	7/4	95	
OR MANE AND ADDRESS	OF BERSON N	MIO COMPLETED OF	105 05 05 101 um		21	_			U					

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32 REGISTRAR'S SIGNATURE



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	PHYSICIAN:
VISION	AL OR ATTENDING PHYSICIAN;
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Nazeer Ahmad July 5:37 P 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday, IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 219-29-0485 DAYS 1 🔯 M 2 🗌 F 78 July 1, 1917 India Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 18754 Cross Country Lane Gaithersburg Montgomery RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Gaithersburg Montgomery 1 TES 2 T NO funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 18754 Cross Country Lane 20879 USA Perm. Resident 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No if yes, specify Cuben, Mexican, Puerto Ricen, etc.)
1 ☐ YES 2 ☒ NO Specify: 14. RACE -- American Indian, Black. White, etc. 1 Never Married 2 Merried BY 3 🔀 Widowed 4 🗌 Divorced Asian 16a. DECEDENT'S USUAL OCCUPATION

**Chee kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION ecity only highest grade complete 16b. KINO OF BUSINESS/INDUSTRY /Sne Elementary/Secondary (0-12) College (1-4 or 5+) 12 Self-employed Brokerage once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ali Ahmad notified at Unknown BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Riaz Ahmad 18754 Cross Country Lane, Gaithersburg, MD 20879 be 20e. METHOD OF DISPOSITION
1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION -- City or Town, State must George Washington Cemetery 7/13 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITYHINES-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 completely filled in by the rial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate intarvai Between IMMEDIATE CAUSE (Final Onaet and Daath the disease or condition event, reaulting in death) the attending physician and con Mental Hygiene prior to burial, traumatic CERTIFICATION Sequantially list conditions, AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING other CAUSE (Disease or Injury AS A CONSEQUENCE OF DUE TO (OR that initiated aventa resulting in death) LAST 0 injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS certificate has been signed by h the State Dept. of Health and AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 1 TYES 2 NO Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) item **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5- Residence 6 Other (Specify) 0 27. MANNER OF OEATH 28e. DATE OF INJURY with t 28h TIME OF 28c. INJURY AT WORK? marked, 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES DIRECTOR: After the hours after death v 2 NO BY Investigation 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 60 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Homicide item 29e. CERTIFIER 1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. FUNERAL (within 72 h Ξ 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occured at the time, date end piece, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1: 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D41866 9 13

19261 Montgomery Viiage Ave. Suite GlO, Gaithersburg, MD

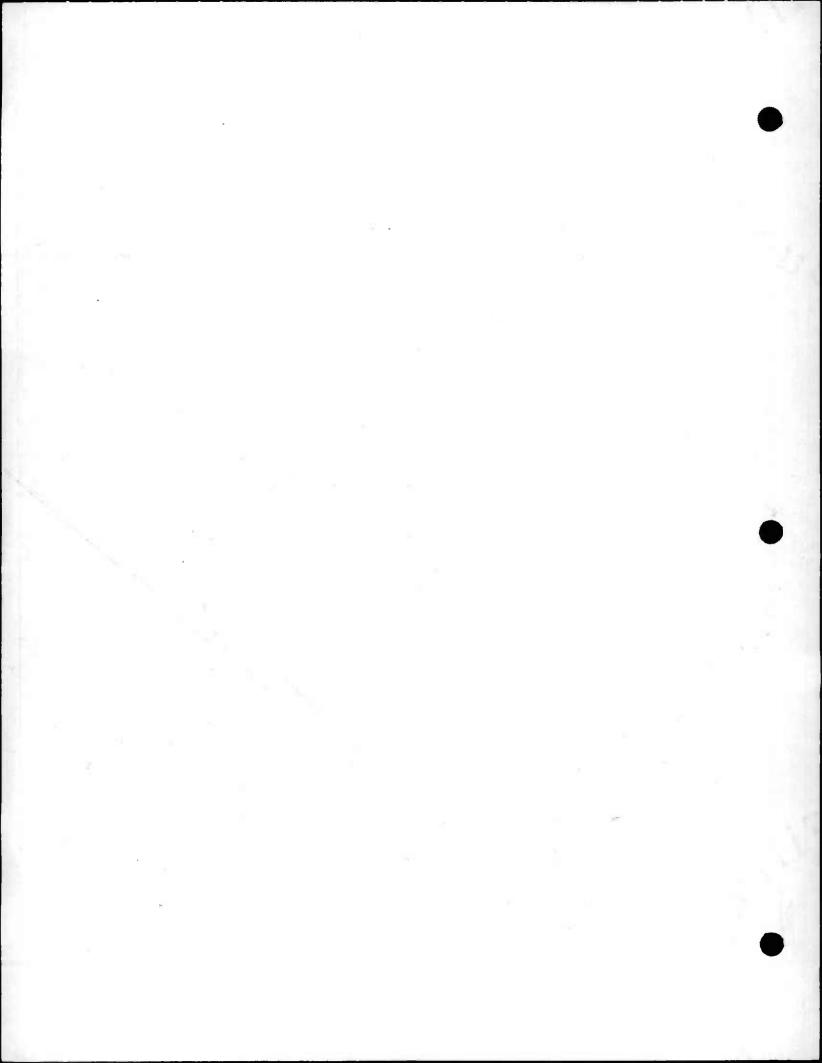
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1995

32. BEGISTHAR'S SIGNATURE
filla d'auction hardall

Kanan Hudhud, M.D.

20879



DIVISION OF VITAL RECORDS, P.O. BOX 68760

STORY OF COMME	TO RE COMPLETED BY PHYSICIAN MEDICAL CEPTIFICATION
examiner must be notified at once.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ne funeral director, page 5 should be detacher al.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
ir death. Page 6 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hosp
	×

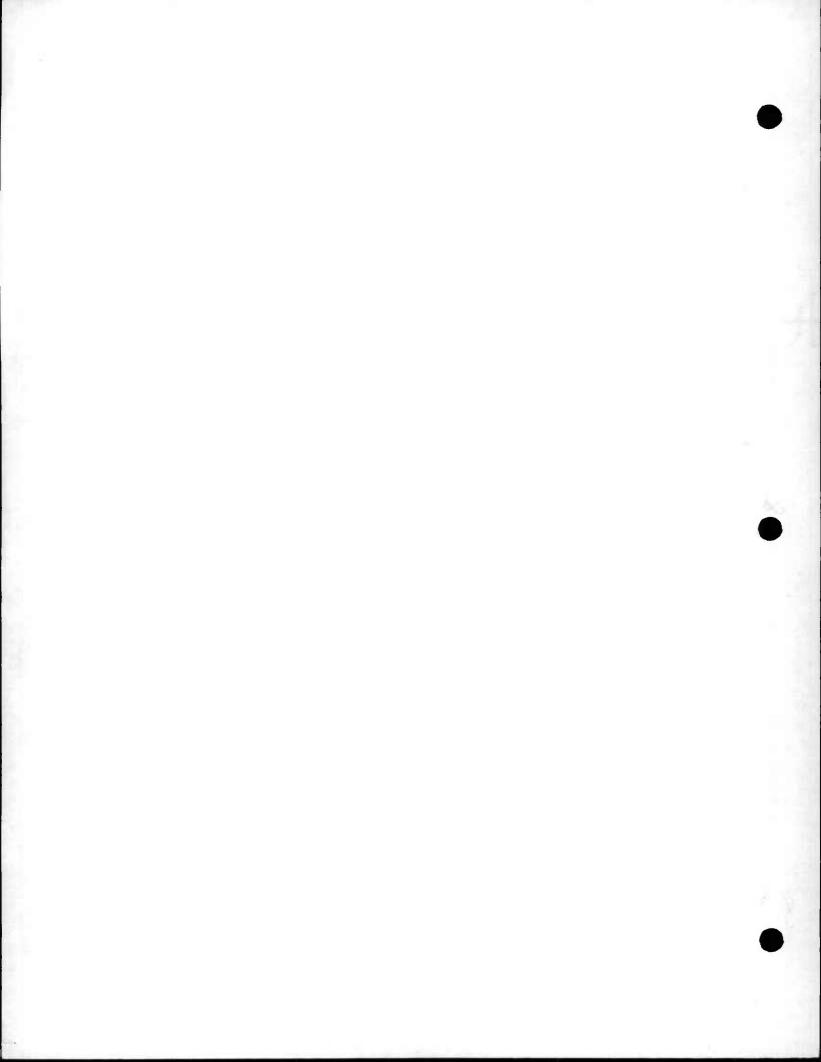
												(95	23309
	1 - STATE REGISTRAR		STATE OF N	MARYLAND /	DEPAR	RTMENT	OF H	EALTH DEAT	AND I	MENTAL	HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, M	fiddle, Last)								2. DATE O				3. TIME OF DEATH
	Milton	B.	Allman	ì						July	13,	ay 1995	YEAR	11:25 P M
	4. SOCIAL SECURITY NUMBER	9	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDER	1 YEAR	IF UNDER		7. DATE O	F BIRTH		8. BIRTI	HPLACE (State or Foreign
	577-60-0125	1	1 🖾 M 2 🗌 F	84	YRS.	MONTHS	DAY\$	HOURS	MIN.	೦೭ ಕ್ಷದ್ದರ್ಭ			Count	**
	9a. FACILITY NAME (If not instit	tution, give str	eet and number)			9b, CITY	TOWN C	R LOCATION	ON OF DE		1910		West	<u>Virginia</u>
DIRECTOR	4608 Coop		ne					Beth				3 0.00	701.00	gomery
<u>n</u>		Ob. COUNTY			10c. CIT	Y, TOWN C	OR LOCAT	ION	_					10d. INSIDE CITY
8	Maryland	M	ontgomer	77					Do+h	nesda				LIMITS7
3	10e. STREET AND NUMBER	171	onegomer	<u>y</u>	1		101	ZIP CODE		iesua		100 01	TIZEN OF	WHAT COUNTRY?
FUNERAL	4600	0	er Lane							_				
ŽΙ	11. MARITAL STATUS	СООР	12. WAS DECEDEN	T EVER IN II C AS	MED	140	WA 050		2081					States
디	1 Never Married 2 Me	erried	FORCES? 1	X YES 2 I	NO		If yea, spe	cify Cuba	n, Maxica	NC ORIGIN? n, Puerto Ric	(Specify Yea can, etc.)	n or No—	14. RAC Blac	E — American Indian, ik, White, atc.
B	3 Widowed 4 Divorce	ed .	IF YES, GIVE W			'	1 🗌 YES	2 X NO	Specify	<i>r:</i>			Spec	
0	15. DECED	ENT'S EDUC	ATION		CEDENT'S	I I I I I I	CCUBATIO	and a		405.6	(IND OF BU		<u> </u>	White
COMPLETED	(Specify only hi	ighest grade o	completed)	(G	ive kind of Do NOT us	work done o	during mo:	st of working	g	100. 1	CIND OF BU	SINESS/IN	DUSTRY	
7	Elementary/Secondary (0-12	1)	College (1-4 or 5	.)										
₹	17. FATHER'S NAME (First, Midd	tto 1 == 0)	2	рері	uty D)1V1S	on D						of Ag	riculture
	17. PATHER'S HAME (PISS, MIGO							18. MOTH	HER'S NA	ME (First, Mi	ddle, Maiden	Sumame)		
B			c Upton								ıud	Bus		
ဥ	19a. INFORMANT'S NAME (Type			19	b. MAILING	AODRESS	Street a	nd Number	or Rural F	Route Numbe	, City or Tow	n, State, Zi	ip Code)	
- 1	Ordella S.			4	4608	Coop	er L	ane	Beth	esda,	Mary	yland	3 208	316
	20g. METHOD OF OISPOSITION 1. Donation 6 □ Other (Sc	N 3 ☐ Ramor	val from State	20b. PLACE	metory or o	ther place)	Ĵυ	1v	16,1	995			- City or To	
	21. SIGNATURE OF FUNERAL S		NSEE	_ India	an MC					DR ITW				Virginia
	> \(\)	0	2/	/ * ***	2225	Ro Be	bert thes	da-C	Pump	hrey Chas	Funer se, Ir	ral H	lome/	Wisconsin
	23. PART i. Enter the dise	2000 700	mpilestions the	MU(0335	AV	enue	вет	nesd	la, Ma	rylar	nd 20)814-	
- 1	shock, or hesi	rt fallure. L	ist only one csu	se on each line).).	iot entar	tne mod	de of dyl	ng, suci	n as cardia	ic or respi	retory a	rrest,	Approximate interval Between
	IMMEDIATE CAUSE (Final													Onset and Death
	disease or condition reaulting in death)	a .	Metast	atic E	3ladd	ler	Canc	er						2 Years
1			DUE TO	(OR AS A CONSE	OUENCE O	F):								
z I	Consentially list and distant	b.												
	Sequantially list condition if any, leading to immedia	ite	DUE TO	(OR AS A CONSEC	DUENCE O	F):								
ঠ ∥	cause. Enter UNDERLYING CAUSE (Disease or injury													
CERTIFICATION	that initiated events		DUE TO	(OR AS A CONSEC	DUENCE OF	F):								
	resulting in death) LAST	d.												
	DADT II ONE I - III A													
⋠∥	PART ii. Other significant	conditions	contributing to	death but not r	esuiting	in tha un	derlying	cause g	jiven in	Part I. 2	4a. WAS AN PERFOR		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă										_	YES 2	₩ NO		COMPLETION OF CAUSE OF DEATH?
岁												••		1 TYES 2 NO
PHYSICIAN: MEDICAL	DID TOBACCO USE	CONTR	IBUTE TO CA	USE OF DEA	TH YE	S 🗆 N	10 D	UNC	ERTAIN	N KI				- M
₹	25. WAS CASE REFERRED TO M				E OF DEAT									
မ္တူ	EXAMINER?		HOSPITAL: 1 Inpatient 2	FR/Outpetlant 3	□ noa	OTHER	t:	. M	-14	8 🗆 Other (
Ë∥	27. MANNER OF DEATH		28a. DATE OF		28b. TIM		28c. INJL		aldenca		Specify)	WHITE OF	011050	
	1 X Natural 5 Per		(Month, D			ÜRY	WOI	RIC?	1 100	200. DESC	NIBE HOW I	NJUNT OC	CORED	
ਨੂੰ	- Distriction	estigation	24 BLACE O	E IN HURW AA N				ES 2	NO					
유		uld not be ermined	building,	F INJURY — At ho etc. (Specify)	me, farm, s	mreet, facto	ory, offica	1		28f. LOCAT City or	ION (Street a Town, State)	and Numbe	r or Rural F	Route Number,
COMPLETED														
ᆲ	29a. CERTIFIER (Check only	ING PHYSIC	IAN: To the best of	my knowledge, de	ath occurr	ed at the ti	me, date	and place,	end dua	to the couse	(a) and man	ner aa ata	ted.	
<u>₹</u> ∥	one) 2 MEDICA	L EXAMINER	On the basis of ex	amination end/or i	Investigatio	n, in my o	pinion, de	ath occur	nd at the	time, date a	nd place, an	d due to t	he ceuee(s	a) and manner as stated.
	28h. SIGNATURE AND TITLE OF	CHATTIERS	than-		_									
B	00	MY	Vrn						NSE NUM	BEH				(Month, Day, Year)
o II	V	- 0	1/					17	767				July	14, 1995

M.D. 3301 New Mexico Avenue, NW, #311, Washington,

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Stephen W. Dejter, 31. OATE FILED (Month, Day, War) JUL 17 1995

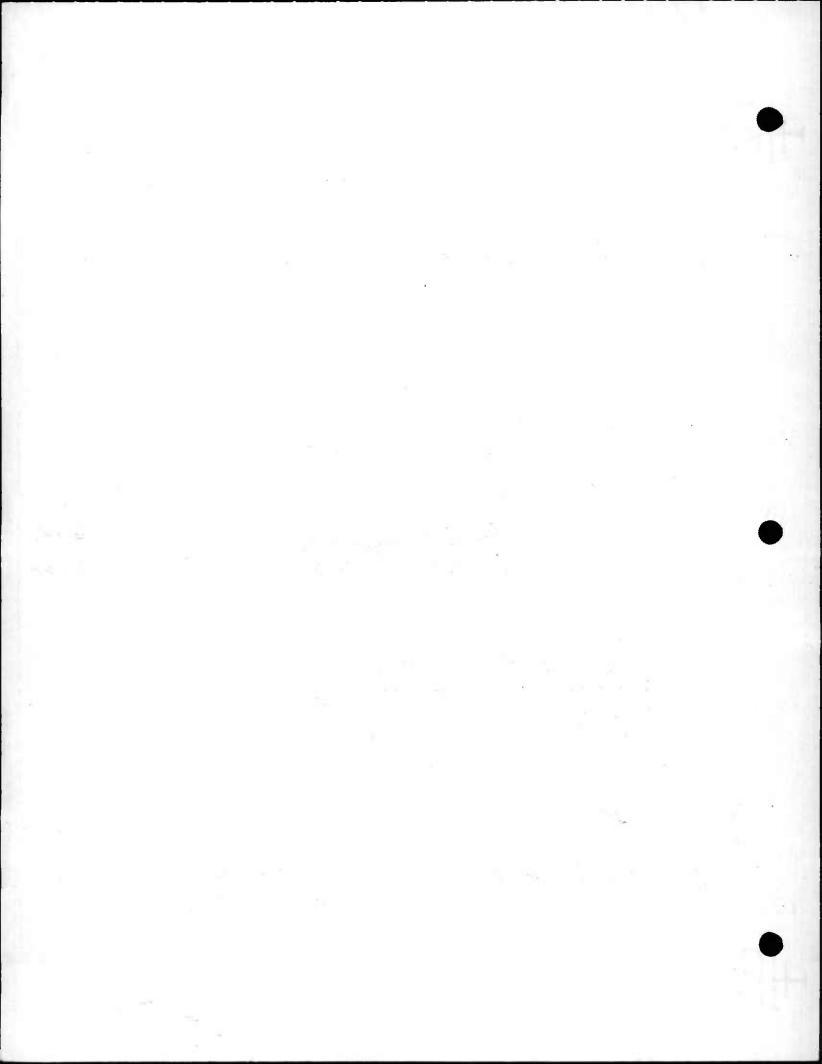
20016



FOR STATE REGISTRAR

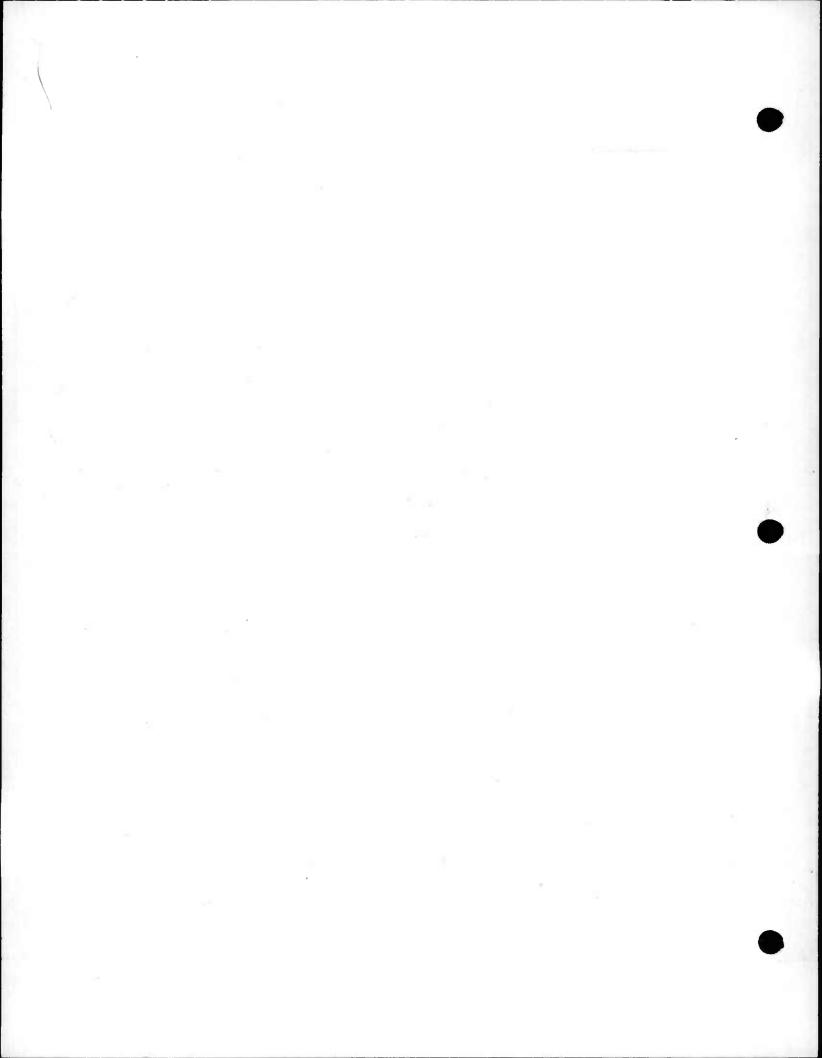
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	1120011011				LHIII	CALL	. OF	DEAL		R	EG. NO.				
	1. DECEDENT'S NAME (First,									2. DATE OF D	DEATH		VEAD	3. TIME OF	DEATH
		GOLDIE		BOBB						JULY	16,	1995	YEAR	9:1	0 A. M
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER		IF UNDER		7. DATE OF B (Month, De	WRTH		8. BIRTH	PLACE (State	or Foreign
	578-60-9262		1 ☐ M 2 🛣 F	88	YRS.	MONTHS	DAYS	HOURS	MIN.	APRIL	15,	1907	PO]	LAND	
	9e. FACILITY NAME (If not in.					9b. CITY,	TOWN C	R LOCATIO	ON OF OE	ATH		9c. COU	NTY OF D	EATH	
5	MANOR CARE -		AC				POT	OMAC				M	ONTG	OMERY	
ᇈ	RESIDENCE OF DEC														
DIRECTOR	IOV. SIATE	10b. COUNTY				Y, TOWN O			α .					10d. INSIDE	CITY 17
	40 070557 410 1111155				WA	PHTM		, D.						1 X YES	2 NO
RA	10e. STREET AND NUMBER	HIGERMA	A **********		# = 0.0		101.	ZIP CODE						HAT COUNT	
FUNERAL	4000 MASSACI				_				016				red :	STATE	S
E	11. MARITAL STATUS 1 Never Married 2		12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AF	RMED NO	13. V	MAS DEC	ENDENT O	F HISPAN	IIC ORIGIN? (Sp n, Puerlo Ricen	ecify Yes	or No	14. RACE Black	- America: , White, etc.	n Indien,
B	3 X Widowed 4 Divo		IF YES, GIVE V	AR OR DATES		1	T YES	2 X NO	Specify	<i>r</i> :	,,		Specif	ly:	
	15. DEC	DENT'S EDUCA	TION	160 0	ECEDENT'S	HELIAL OC	CHRATIC							WHIT	E .
E	(Specify only	highest grade of	ompleted)	(0	live kind of v	vork done d	furing mos	st of working	g	160. KIN	O OF BUS	INESS/IND	USTRY		
7	Elementary/Secondary (0-8TH	-12)	College (1-4 or 5)	USEW.					0	WN H	OME			
COMPLETED	17. FATHER'S NAME (First, Mi	ddle. Lest)						16 MOTH	EDIC MAI						122
	SOLOMO		LOVE						NNA	ME (First, Middle	IEDM.				
띪	19e. INFORMANT'S NAME (7)	ne/Print)		10	h MAII INC	ACCRECE	/Compat or			Route Number, C					
2	ANITA RATAI		UGHTER)	6	104	EAST	TEW	STRI	er nunii r EET .	BETHE.	IN OF IOWN	, State, Zip	208]	17	
	20. METHOD OF DISPOSIT	ON		20b. PLACE						OATE					
	20e. METHOD OF DISPOSIT	n 3 🗆 Remov	ni from State	BNAT						7/18		ATION —			AND
	21. SIGNATURE ON FUNERAL			/ D MILL	LOIM	_		D ADDRES	S OF FAC		OAU	N III.	ا ربانا	MARYL	AND
	• 4		7 4	4 .		DA	ANZA	NSKY-	-GOL	DBERG 1					
-	///	kel	m./	use		11	170	ROCKY	/ILL	E PIKE	, RO	CKVI	LLE,	MD 20	0852
	23. PART I. Enter the di shock, or he	seases or co	mplications tha st only one cau	t caused the de	eath. Do n	ot anter	the mod	de of dyle	ng, suct	n as cerdiac	or reapir	atory arr	est,		oximate
	IMMEDIATE CAUSE (Fin		A	SO OH BOOK MIC	581.1										ral Between t and Death
	disease or condition resulting in death)	+ .	Re	mal a	a Tu	PRI	cie							6	Mo
	,		DUE TO	OR AS A CONSE	QUENCE OF	96		7			-			+	
z I	Sequentielly ilst condition	h.	Di	aleles	0 1	Yel	ely	tell						14	esu
ĔI	if any, leeding to immed	liate	DUE TO	(OR AS A CONSE	DUENCE OF):"								1	
<u> </u>	Cause. Enter UNDERLY!! CAUSE (Disease or Injur														
ËI	that initieted eventa		OUE TO	(OR AS A CONSE	OUENCE OF):									
CERTIFICATION	The or an indian	d.													
	PART II. Other significer	t conditiona	contributing to	death put not i	esulting i	n the und	darlying	cause g	iven in i	Part I. 24a.	WAS AN	WTOPSY	24b.	WERE AUTOR	PSY FINDINGS
MEDICAL	acter		estic	Alex	9	12:0	ca	u			PERFORM		11	AWAILABLE P	RIOR TO
요Ⅱ	Vilen	lan.	4	+ 15	Los					_ ''_	YES 2	NO		OF DEATH?	
- 1	DID TOBACCO US	SE CONTRI	BUTE TO CA	LISE OF DEA	TU VE	C D A	IO DE	LINICI	EDTAIN					1 TYES 2	™ NO
₹	25. WAS CASE REFERRED TO		DOIL TO CA		E OF DEAT			OIACI	KIMIN	1 1	-				
200	EXAMINER?		HOSPITAL:		T	OTHER	:								
PHYSICIAN:	27. MANNER OF OEATH		28a. DATE OF		28b. TIME		28c, INJU		idence	6 Other (Spe 26d, DESCRIB		IIIIIV OCC	UDED		
		ending	(Month, D	ty, Year)	INJ	JRY M	WOF	K? ES 2 -	NO	Zou. DESCRIB	L HOW IN	JOH! OCC	ONED		
B	2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	vestigation	28e. PLACE O	F INJURY — At ho	me, term, a	rest. facto				261. LOCATION	4 /Street or	ad Alexandras	or Rumi D	auto Mumbas	
		could not be etermined	building,	etc. (Specify)			,,			City or Tow	vn. State)	TO PUBLICATION	or noral m	JOIN MUNICH,	
9 1	29e. CERTIFIER		F-171.0165		1250		_								
0.			AN: To the beet of												
∑ ∥		AI EVAMMED.		minimental euchor	investigation	i, in my op	einion, de	ath occure	d at the t	time, date end p	place, end	due to the	ceuse(e)	end menner	ee stated.
₩ 00 00	one) 2 MEOIC	EXAMINER:													
шШ			0 1				- 1	29c. LICE			- 1			(Month, Day,	
TO BE COMPLETED	29b. SIGNATURE AND TITLE	OF CERTIFIER	Seal					29c. LICE		BER DO	- 1			Month, Day,	
шШ	29b. SIGNATURE AND TITLE	PERSON WHO	Seg L COMPLETE CAUS	SE OF DEATH (ITE)			CHE	1	02	00		▶ JU	LY 1		
TO BE	29b. SIGNATURE AND TITLE	PERSON WHO	COMPLETE CAUS 5530 WI	SE OF DEATH (ITE)	AVEN		СНЕ	1	02	00		▶ JU	LY 1		



Amended	em#4.G-film 727 per E.H 9/15/95 P.C ## 199 7/18/95 MRT Montgomery	2023
1 STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE	

		REGISTRAR				CERTI	FICAT	E OF	DEATH		REG. NO.			
		1. DECEDENT'S NAME (First,								2. DATE C	F DEATH			. TIME OF DEATH
			Mar	garet C.	Blak	e				July	15, 1		YEAR	8:15 Am
		4108-30-0639	ER	5. SEX	8. AGE (in yrs. lest birthde		ER 1 YEAR	IF UNDER 24 HRS.	7. DATE O	F BIRTH		8. BIRTHPL	ACE (State or Foreign
Ð		168-30-0637		1 □ M 2 🂢 F	5	6 YRS	MONTHS	DAYS	HOURS MIN.		7,193	39	New New	York
3 should		9a. FACILITY NAME (If not ins	attution, give s	treet and number)			9b. CIT	TY, TOWN	OR LOCATION OF DI				TY OF DEA	
23	CTOR	Manor Care-I		ood				Bet	thesda			Mor	ntgom	ery
—	ECT	RESIDENCE OF DEC	EDENT 10b. COUNT									<u></u>		
Pages	뜨					10c. C	IIY, IOWN	OR LOCAT						Dd. INSIDE CITY LIMITS?
permit.		Maryland 100. STREET AND NUMBER	MC	ntgomery					thesda 1. ZIP CODE					YES 2 X NO
8. %	RAL	10434 Parthe	enon (ourt				10	20817	7		_		AT COUNTRY?
020 physician. burial-transit	FUNE	11. MARITAL STATUS		12. WAS DECEDER	IT EVER IN	IIIS ARMED	112	WAS DEC	CENOENT OF HISPAN		Marath, Mar			tates
215-0020 attending physician. se as the burial-trar		1 Never Married 2 1		FORCES?	YES	2 X NO	, "	If yes, sp	ecify Cuban, Maxica	in, Puarto Ri	can, stc.)	Or NO-	Black, V	- American Indian, Vhita, atc.
15-0 tending as the	ВУ	3 Widowed 4 X Divon	ced	1. 120, 0.12	min on br	1123		I 🗌 YES	3 2 💢 NO Specifi	у:			Specify:	White
			OENT'S EOU			16s. DECEOENT			ON ost of working	18b.	KIND OF BUS	INESS/INDU	ISTRY	
21 al or for u	ET	Elementary/Secondary (0-	1	College (1-4 or 5	+)	life. Do NOT	use retired.)	ost or working					
LAND 21 the hospital or detached for u	COMPL	_		2		Admini	stra	tive	Assistar	nt	Law C	ffice	2	
the hor detach	8	17. FATHER'S NAME (First, Mic	7.7						16. MOTHER'S NA	ME (First, Mi	ddle, Maiden	Surname)		
A P	BE		_	ahtila					Ma	argare	t Zit	z		
MARYLAND retained by the hospit should be detached notified at once.	0	Leslie K. Da							and Number or Rural i					
						111 S	trat	ford	Avenue,	Pitts	field	, MA	012	01
Figoration Page 6 may be all director, page net must be a		20a. METHOD OF DISPOSITION 1 Burial 2 Cremation	n 3 🗆 Ram	oval from State	20b.	PLACE AND DAT	other place	a F		OATE		CATION - C		
- u e -		4 Donation 5 Other (. ,,		U:	nion Ce			July 18,	1995	Hyde	Park	, Ne	w York
ALTIM death. Page tuneral direct. L.	ľ	21. SIGNATORE OF FUNERAL	. SERVICE LIC	ENSEE Y		-	H(OME /F	ND ADORESS OF FA Bethesda-	Chevy	bert Chas	A. Pu	mphr	ey Funeral
BALT ter death. the funera val.		Tycek	ele	J-54	ella	M003	48 W:	iscor	nsin Aven	iue, E	Bethes	da, M	ID 20	814
hours after ed in by the or removal		23. PART I. Enter the dis	seases, or o	complications the	t caused	the death. Do	not ante	r tha mo	de of dylng, suc	h as cardi	ac or respli	ratory arre	st,	Approximate
filled in M		IMMEDIATE CAUSE (Fine		List Only One Car	ase on se	och line.								Onset and Death
~ =		disease or condition resulting in death)	+	Bı	reast	Cancer	-						arrit	10 Years
s760 ted within completely ial, cremat		PERIODE CO. LIVE		DUE TO	(OR AS A	CONSEQUENCE	OF):							20 10015
executed within and completely or burial, crema	8	Sequentially list condition	200	b										
OX 68 ob execut sician and crior to buri	ERTIFICATION	if any, leading to immed cause. Enter UNDERLYIN	liate	DUE TO	(OR AS A	CONSEQUENCE	OF):							
B ficate physic pri		CAUSE (Diseese or Injur		c	(OR AS A	CONSEQUENCE	OE).							
h certifical anding phy Hygiene g or other	Ē	that initieted events resulting in death) LAST		5,52.10	(0111011	CONSCIONAL	or y.							
	B			d										
를 로 를 를	A	PART II. Other significant	t condition	s contributing to	deeth be	ut not resultin	In the u	nderlying	g ceuse given in	Part i. :	24a. WAS AN			ERE AUTOPSY FINDINGS
) 5 BE E	EDICAL										1 TYES 2		cc	MILABLE PRIOR TO OMPLETION OF CAUSE FOEATH?
requires seen signal of Health	ME												1 100	TES 2 X NO
	ż	DID TOBACCO US	E CONT	RIBUTE TO CA	USE O	F DEATH	ES 🔲	NO [UNCERTAIN	N D				
IIAL N: The law icate has State Depr	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HORRITAL		26. PLACE OF DE	-							
ICIAN: The ertificate the State or item	Š	1 - YES 2 X NO		HOSPITAL:	ER/Outpe	stlent 3 🗆 DOA	44 Nu	R: Iraing Hom	e 5 🗆 Residence	8 🗆 Other	Specify)			
PHYSIC this cell with the	PH	27. MANNER OF OEATH		28a. DATE OF (Month, D	ay, Year)		ME OF	28c. INJ WO	URY AT	28d. OESC	RIBE HOW IN	JURY OCCU	REO	
ON OF OR OF After this of death with a marked,	À	1 Netural 5 P	ending rvestigation				M	1 🗆 1	YES 2 NO					
J G K D W			could not be	28e. PLACE C building,	F INJURY stc. (Speci	— At home, farm	, street, fac	ctory, office	•	28f. LOCAT	ION (Street a Town, State)	nd Number o	r Rural Rout	e Number,
DR ATTEN DIRECTOR: hours after item 28 i	ETE		etermined											
	립	29e. CERTIFIER CERTIF	FYING PHYSI	CIAN: To the best of	my knowle	edge, daeth occu	rred at the	time, date	and place, and dua	to the cause	e(a) and man	ner ea state	d.	
HOSPITAL FUNERAL within 72 TANT: If	COMPL	one) 2 MEDIC	EXAMINE	R: On the beels of a	xamination	and/or investige	lon, In my	opinion, d	leath occured at the	time, dete a	nd place, and	dua to the	cause(a) ar	nd manner as stated.
HE FU	ш	29b. SIGNATURE AND TITLE	OF CERTIFIE	<u> </u>					29c. LICENSE NUM	ABER	,	29d. DATE	SIGNEO (M	onth, Day, Year)
TO THE HOSPIT TO THE FUNERA De filed within 7	m	Lila	- ()	on	1	anne	u	-	D39.	456	.	1 7	111	195
	2	30. NAME AND AGORESS OF											19	
9		Lila T. McCo	onnell	, M.D.,	5530	Wiscon	sin A	Avenu	ie, Suite	915.	Chev	y Cha	se, I	MD 20815
1		31. DATE FILEO (Month, Day, Ye	bar)	32, REGISTRA	R'S, SIGNA	TUBE								
	- 1	nn 17	1495	Julia De	WWW.	revolate								



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	BE COMPLETED BY FUNERAL DIRECTOR	2 9 H 10 M
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ed at once.	BE C	17

85, 23312

H	mended # 2	7/27/ STATE OF MAR	95 MK	T/	101/9	Tome	ery	60	1477	14
	1 - STATE REGISTRAR	SIAIE UF MAH	YLAND / DEPAR CERTIE	ICATE OF	DEATH AND I		H YGIENE REG. NO.			0
	1. DECEDENT'S NAME (First, Middle, Last)			IOAIL OI	DEATH	2. DATE OF	DEATH		3.	. TIME OF DEATH
	Laura Outla	and Baube				July	15, DAY	995	YEAR	:31 P M
	4. SOCIAL SECURITY NUMBER	5. SEX 8. A	GE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF	BIRTH		8. BIRTHPL	ACE (State or Foreign
	241-52-3514	1 🗌 M 2 🖔 F	60 YRS.	MONTHS DAYS	HOURS MIN.	(Month, D April	25,19	935	North	Carolina
	9e. FACILITY NAME (If not institution, give st	reet end number)		9b. CITY, TOWN O	OR LOCATION OF DE				NTY OF DEA	
OR	Holy Cross Hospita	11		Silve	r Spring			Mon	tgome	ry
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c CIT	Y, TOWN OR LOCAT	TION				14	Dd. INSIDE CITY
DIRECTOR	Maryland Monto	merv		er Spri					1	LIMITS?
	10e. STREET AND NUMBER	3	10221		. ZIP CODE		T	10g. CITI		AT COUNTRY?
FUNERAL	301 Indian Spring	Drive			20901		- 1	Unit	ed St	ates
S	11. MARITAL STATUS	12. WAS DECEDENT EVE FORCES? 1 X Y	ER IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IC ORIGIN? (S	Specify Yee o			- American Indian, White, etc.
BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR O	R DATES		ecity Cuban, Mexice 2 NO Specify		in, etc.)		Specific	
	15. DECEDENT'S EDUC	1953-1956								White
TE	(Specify only highest grade	completed)		VSUAL OCCUPATION Work done during mo		186. KII	ND OF BUSH	NESS/IND	USTRY	
PLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	1943	Assistar	n t-	Δ+-	torne	3.7		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		Legal	MBBIB CUI	18. MOTHER'S NA					
BE C	Russell Outland	l			Elsie	White		,		
	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street e	and Number or Rural F		City or Town,	State, Zip	Code)	
2	Ian G. Baube		301 In	ıdian Spı	cing Driv	re, Si	lver	Spri	ng, M	D 20901
	20a. METHOD OF DISPOSITION 1 Duriet 2 Cremetion 3 Remo	oval from State	20b. PLACE AND DATE (cemetery, cremetory or of Montgomery	OF DISPOSITION (Va	7°18, 199	DATE DATE	20c. LOCA	ATION —	City or Town	, State
	4 Donation 8 Other (Specify)		Montgomery						, Mar	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSER		Homo / I	OCKTTILL	CILITYROD	ert A	. Pu	mphre	y Funeral ntgomery
	May 1 Total	M	00689	Avenue	Rockviiie	ille,	Maryl	o we and	20850	-2805
	23. PARTI Enter the diseases, or c	amplications that are								
- 1	Ishoek, or heert fellure, I	Liet only one cause of	ised the deeth. Do n	ot enter tha mo	da of dying, suc	h aa cerdiac	or reapira	story arr	eet,	Approximate
	IMMEDIATE CAUSE (Fine)	Liet only one ceuee o	n eech line.		da of dylng, suc	h aa cerdiad	or reapire	story arr	eet,	Approximate Intervel Between Onsat and Daeth
	Tushoek, or neert fellure, s	Metastat	ic Brain C	Cancer	da of dying, suc	h aa cerdiad	or reapire	atory arm	eet,	Intervel Between
	IMMEDIATE CAUSE (Finei disease or condition	Metastat	n eech line.	Cancer	da of dying, suc	h aa cerdiad	or reaptra	atory arr	eet,	Intervel Between Onsat and Daeth
NOI	IMMEDIATE CAUSE (Finei disease or condition resulting in death) Sequentielly list conditione,	Metastat DUE TO (OR A	ic Brain C	Cancer	da of dylng, suc	h aa cerdiac	or reapire	atory arm	eet,	Intervel Between Onsat and Daeth
CATION	IMMEDIATE CAUSE (Fine) disease or condition reculting in death) Sequentielly list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING	Metastat DUE TO (OR A	ic Brain C	Cancer	da of dying, suc	h aa cerdiac	or reapira	atory arm	eet,	Intervel Between Onsat and Daeth
IFICATION	IMMEDIATE CAUSE (Fine) disease or condition reculting in death) Sequentielly list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events	Metastat DUE TO (OR A	ic Brain C	Cancer Fi:	da of dying, suc	h aa cerdiac	or reapira	atory arr	eet,	Intervel Between Onsat and Daeth
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L CERTIFICATION	IMMEDIATE CAUSE (Fine) disease or condition reculting in death) Sequentielly list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted events reaulting in death) LAST	Metastat DUE TO (OR A DUE TO (OR A	ic Brain C as a consequence of as a consequence of	Cancer F): F):						Intervel Between Onsat and Daeth Unknown
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	IMMEDIATE CAUSE (Fine) disease or condition reculting in death) Sequentielly list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted events reaulting in death) LAST	Metastat DUE TO (OR A DUE TO (OR A	ic Brain C as a consequence of as a consequence of	Cancer F): F):		Pert I. 24	s. WAS AN AI	UTOPSY IED?	24b. Wi	Intervel Between Onsat and Daeth Unknown Unknown ERE AUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
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	IMMEDIATE CAUSE (Fine) disease or condition reculting in death) Sequentielly list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initieted events reautting in death) LAST PART ii. Other aignificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL	DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A E E E E E E E E E E E E E	ic Brain C as a consequence of as a consequence of as a consequence of	Cancer F): In the underlying IN (Check only one)	g cause given in	Pert I. 24	a. WAS AN AI PERFORM	UTOPSY IED?	24b. Wi	Intervel Between Onsat and Daeth Unknown Unknown ERE AUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?
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BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Fine) disease or condition reculting in death) Sequentielly list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initieted events reaulting in death) LAST PART II. Other algnificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO 27. MANNER OF DEATH 1 X Netural 5 Pending	Metastat DUE TO (OR / DUE TO (OR / DUE TO (OR / DUE TO (OR / DUE TO (OR / BE CONTRIBUTING TO deet RIBUTE TO CAUSE HOSPITAL: Inpellent 2 ER/ 28e. DATE OF INJU	ic Brain C as a consequence of as a consequence of as a consequence of the but not resulting (COF DEATH YE 28. PLACE OF DEAT Dutpetlent 3 DOA RY 28b. TIMI INJ URIY — At home, farm, a	Cancer F): In the underlying If (Check only one) OTHER: 4 Nursing Home UNY M 1 Y	UNCERTAIN 5 G Reeldence URY AT (ES 2 G NO	Pert I. 24	a. WAS AN AI PERFORM X YES 2 [Decily)	UTOPSY IED? NO	24b. WI	Intervel Between Onsat and Dasth Unknown ERE AUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE POEATH? YES 2X NO
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PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Fine) disease or condition reculting in death) Sequentielly list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initieted events reaulting in death) LAST PART II. Other algnificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be datermined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER	DUE TO (OR A DU	ic Brain C as a consequence of as a consequence of as a consequence of as a consequence of the but not resulting (COF DEATH YE 26. PLACE OF DEAT Dutpetlent 3 DOA RY 28b. TIMI Bry URY — At home, farm, a Specify)	Cancer F): In the underlying In the underlying In (Check only one) OTHER: 4 Nursing Hom B 28c. INJ URY WO 1 V	UNCERTAIN 5 Revidence URY AT RK7 (ES 2 NO end piece, and due eath occured at the	Pert I. 24 1 1 2 2 3 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3	a. WAS AN AN PERFORM PERFORM YES 2 [Pecily] BE HOW INJ ON (Street endown, State)	UTOPSY IED? NO NO JURY OCC d Number er ee state	24b. WII AW CC OF 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Intervel Between Onsat and Dasth Unknown Unknown ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2½ NO
BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Fine) disease or condition resulting in death) Sequentielly list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initieted events reaulting in death) LAST PART II. Other algnificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO 27. MANNER OF DEATH 1 X Netural 5 Pending Investigation 3 Suicide 8 Could not be datermined 29e. CERTIFIER (Check only) CERTIFYING PHYSIC	DUE TO (OR A DU	ic Brain C as a consequence of as a consequence of as a consequence of as a consequence of the but not resulting (COF DEATH YE 26. PLACE OF DEAT Dutpetlent 3 DOA RY 28b. TIMI Bry URY — At home, farm, a Specify)	Cancer F): In the underlying In the underlying In (Check only one) OTHER: 4 Nursing Hom B 28c. INJ URY WO 1 V	UNCERTAIN 5 Revidence UNY AT RK7 (ES 2 NO	Pert I. 24 1 1 2 2 3 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3	s. WAS AN AI PERFORM PERFORM X YES 2 [DECITY ON (Street encown, State) e) end menned a piece, end	UTOPSY IED? NO JURY OCC d Number er ee state due to the	24b. WIND AND COLOR OF THE PROPERTY OF THE PRO	Intervel Between Onsat and Dasth Unknown Unknown ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2½ NO
BE COMPLETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Fine) disease or condition reculting in death) Sequentielly list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initieted events reaulting in death) LAST PART ii. Other algnificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CETIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SUSTATURE AND TITLE OF CERTIFIER	DUE TO (OR A DU	ic Brain C as a consequence of as a consequence of as a consequence of as a consequence of the but not resulting to the b	Cancer F): In the underlying In (Check only one) OTHER: 4 Nursing Home E OF URY 28c. INJI WO 1 Y street, tactory, office one of the time, date on, in my opinion, decease.	UNCERTAIN 5 Revidence URY AT RK7 (ES 2 NO end piece, and due eath occured at the	Pert I. 24 1 1 2 2 3 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3	s. WAS AN AI PERFORM PERFORM X YES 2 [DECITY ON (Street encown, State) e) end menned a piece, end	UTOPSY IED? NO JURY OCC d Number er ee state due to the	24b. WIND AND COLOR OF THE PROPERTY OF THE PRO	Intervel Between Onsat and Daeth Unknown ERE AUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2X NO
COMPLETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Fine) disease or condition reculting in death) Sequentielly list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initieted events reaulting in death) LAST PART II. Other aignificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 NO 27. MANNER OF DEATH 1 X Netural 5 Pending Investigation 3 Suicide 8 Could not be datermined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29h SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	DUE TO (OR / DUE T	ic Brain C as a consequence of as a consequence of as a consequence of as a consequence of the but not resulting to the b	Cancer F): In the underlying	TO CAUSE GIVEN IN TO CAUSE GIVE	Pert I. 24 1] 8 Other (S) 28d. DESCRI 28t. LOCATIC City or 76 to the cause(time, date end	s. WAS AN AI PERFORM PERFORM YES 2 [Decily) DN (Street encown, State) e) end menned plece, end	UTOPSY IED? NO NO NO NO NO NO NO NO NO N	24b. Will All CC OF 1 1 CURED or Rural Rout ed. e ceuse(e) er SIGNED (Mill — /	Intervel Between Onsat and Dasth Unknown ERE AUTOPSY FINDINGS (AILABLE PRIOR TO SIMPLETION OF CAUSE FOEATH? YES 2X NO To MATTER TO MATTER TO SIMPLET ON T
BE COMPLETED BY PHYSICIAN: MEDICAL	IMMEDIATE CAUSE (Fine) disease or condition reculting in death) Sequentielly list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury thet initieted events reaulting in death) LAST PART ii. Other algnificent conditions DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined 29e. CETIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SUSTATURE AND TITLE OF CERTIFIER	DUE TO (OR / DUE T	ic Brain C as a consequence of as a consequence of as a consequence of as a consequence of the but not resulting (E OF DEATH YE 28. PLACE OF DEAT Dutpetlent 3 DOA RY 28b. TIMI INJ URY — At home, farm, a Specify) DEATH (ITEM 27) (Type, 99 Lambert	Cancer F): In the underlying	TO CAUSE GIVEN IN TO CAUSE GIVE	Pert I. 24 1] 8 Other (S) 28d. DESCRI 28t. LOCATIC City or 76 to the cause(time, date end	s. WAS AN AI PERFORM PERFORM YES 2 [Decily) DN (Street encown, State) e) end menned plece, end	UTOPSY IED? NO NO NO NO NO NO NO NO NO N	24b. Will All CC OF 1 1 CURED or Rural Rout ed. e ceuse(e) er SIGNED (Mill — /	Intervel Between Onsat and Daeth Unknown ERE AUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2X NO

DIVISION OF VITAL RECORDS, P.O. BOX 68760	within 24 nouns after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complicitly filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remained.	ent, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 6876	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Fage 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filted in by the tuneral do be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or remater, or rematers	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT (OF HEALTH AND	MENTAL HYGII			
	1. DECEDENT'S NAME (First, Middle, Last)			· · · · ·		2. DATE OF DEATH	17.7	3. TIME OF DEATH	
	GERALDINE	В.	В	YRAM		July 18,	1995 Y	12:55 A M	
ij	4. SOCIAL SECURITY NUMBER		In yrs. lest birthday)	MONTHS 0	EAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year	8.	BIRTHPLACE (State or Foreign Country)	
	430-30-3339		55 YRS.		-3 1-3/14 494.	Nov 6 19		est Virginia	
œ	9a. FACILITY HAME (If not institution, give stre				OWN OR LOCATION OF D	EATH		Y OF DEATH	
DIRECTOR	Memorial Hospital			Cumb	erland		Alle	egany	
H	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR	LOCATION			10d. IHSIDE CITY LIMITS?	
	WV Mine	cal	В	urlin	gton			1 YES 2 NO	
RAL	10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?	
FUNERAL	Rt 1 Box 223				26710			S.A.	
5	1 Never Married 2 Married	12. WAS DECEDENT EVER IF FORCES? 1 YES	2 \(\sum \) HO	If y	B DECEMBENT OF HISPA es, specify Cuben, Maxico	en, Puerto Rican, etc.)	Yea or No- 14	I. RACE — American Indian, Black, White, etc.	
B	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES	1 -	YES 2 N HO Specif	y:		Specity: White	
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	(TION omoleted)	16a. DECEDENT'S	USUAL OCCI	JPATION	18b. KIHD OF	BUSINESS/IHDUS		
91	Elementary/Secondary (0-12)	College (1-4 or 5+)		2,011	ng most of working				
MP	12		Homemak	er			Home		
ဗ	17. FATHER'S HAME (First, Middle, Last) Waitman McClung	~				ME (First, Middle, Maid	en Sumame)		
BE	19a. IHFORMANT'S HAME (Type/Print)	<u>ś</u>	10h MAII INO	ADDRESS (C	Ruth	Adkins			
2	Charles E. Byram				223 Burl:			_	
	20e. METHOD OF DISPOSITIOH 1	20b	PLACE AND DATE O	F DISPOSITION	ON (Name of	DATE 20c.	LOCATION - CIN		
	1 A Burlet 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	al from State	etery, crematory or of Comac Memo	rial Ga	rdens July 2	1	Keyser,		
- 1	21. SIGNATURE OF PUMERAL SERVICE LICE	NSEE			ME AHD ADDRESS OF FA	CILITY			
	A.Cicum V.	tu. K			ruck-Smith South Main			1111 06706	
	23. PART I. Enter the diseases, or co	mplications that ceused	the death. Do n	ot enter th	e mode of dying, auc	h as cardiec or rea	neyser,	t, Approximate	
ı	ahock, or heart-failure. LI IMMEDIATE CAUSE (Fine)	at only one cause on ea	ach line.					Interval Between Onset and Death	
	diament or an allelin	Acute Myoca	rdial Ir	nfarct	ion			1 Hour	
1	resulting in death) a. Acute Myocardial Infarction OUE TO (OFF AS A CONSEQUENCE OF):							1 11001	
Z	Sequentially list conditions. Due To (or as a consequence of):								
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING								
윤	CAUSE (Diseeze or Injury that initieted events	Intractable DUE TO (OR AS A	CONSEQUENCE OF):	6 W				
Ē	resulting in death) LAST							!	
Ö	PART II. Other algnificant conditions	contributing to death by	ut met manulala a l						
CAL	The state of the s	contributing to deeth be	at not readiting in	n the unde	riying ceuse given in	Part I. 24a. WAS PERF	AH AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
						1 □ YES	2 10	COMPLETION OF CAUSE DF DEATH?	
Σ	DID TOBACCO USE CONTRI	BUTE TO CAUSE O	E DEATH VE	S 🗆 NO	UNCERTAIL	<u></u>		1 TYES 2 NO	
MA	25. WAS CASE REFERRED TO MEDICAL		A PLACE OF DEAT						
PHYSICIAN:		HOSPITAL:	atlent 3 DOA	OTHER:	Home 5 - Residence	8 Other (Specify)			
후	27. MAHNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28	. INJURY AT WORK?	28d. DESCRIBE HOV	V INJURY OCCUR	IEO	
BY	1 Hatural 5 Pending 2 Accident Investigation	(mortor, Day, rour)	inst		YES 2 HO	- 111 0111			
	3 Suicide 8 Could not be	28e, PLACE OF IHJURY building, atc. (Speci	— At home, term, a	lreet, factory,	office	281. LOCATION (Stree City or Town, Ste	at end Number or I	Rursi Route Number,	
	4 Homicide determined								
4 Homicide determined determined City or lown, Stete) 299. CERTIFIER (Check only one) 2 MEDICAL EXAMIHER: On the basis of examination end/or investigation, in my opinion, death occursed at the time, date and place, and due									
S I	2 MEDICAL EXAMIHER:	On the basis of examination	end/or investigation	n, in my opini	on, death occursd at the	time, date end piece,	and due to the cr	euse(e) end manner ee stated.	
BE (296. SIGNATURE AND TITLE OF CENTIFIER	FORM	MA		29c. LICEHSE HUN	MBER	29d. DATE SI	IGNED (Month, Day, Year)	
<u>و</u> ا	AS NAME AND ADDRESS OF STREET	1000	1117		D 23371		Jh	18/92.	
	30. NAME AHD ADDRESS OF PERSON WHO				Cumbowlon	A MD 215	:02	0	
-	Dr. Q Zaman John	son Heights			Cumberran	iu, riii 215	.02		
	JUL 24 19	32. REGISTAR'S SIANA	uclian Rand	g.ll.					

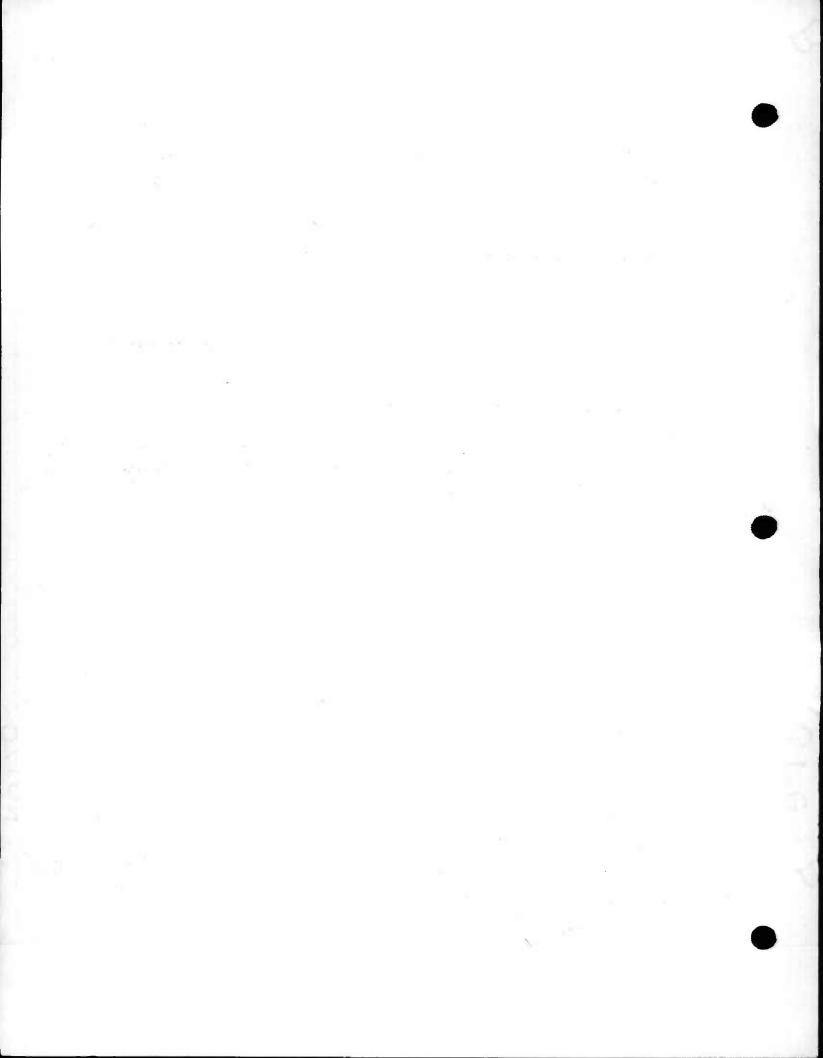
4.25

DIVISION OF VITAL RECORDS, P.O. BOX 68760. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with about after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Debt. of Health and Mental Hydiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGIS	TI
1. DECEDENT	*
JEAN	
4. SOCIAL SI	EC
216	7
9a. FACILITY	N
650 RESIDEN	_
10a. STATE	<u>C</u>
MARY	
10e. STREET	A
650	
11. MARITAL	S

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CE	RITER	CATE O	F DEAT	ГН	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH		1	3. TIME OF DEATH
	JEAN A RENDES	BIBBY						JULY 18	1995	YEAR	2:52 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. last I	birthday)	IF UNDER 1 YEAR	R IF UNDER	24 HRS.	7. DATE OF BIRTH		A BIRTH	PLACE (State or Foreign
	216 74 6868			ONTHS DAY		MIN.	(Month, Day, Year)		Country	y)	
		1 M 2 X X	87					FEB 2, 1			WYORK
~	9a. FACILITY NAME (If not institution, give	street and number)		1	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH					EATH	
Ö	650 WASHINGTO	N STREE	e T		CUMBER	LAND			ALI	LEGA	YY
DIRECTOR											
2				10c. CITY,	TOWN OR LO	CATION					10d. INSIDE CITY LIMITS?
	MARYLAND ALI	LEGANY		CUI	MBERL	AND					1 X YES 2 NO
AL	10e. STREET AND NUMBER					101. ZIP CODE	E		10g. CITI	ZEN OF W	HAT COUNTRY?
FUNERAL	650 WASHINGTO	N STREE	T			215	502			US	A
Z	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.S. ARM	ED	13. WAS D			IC ORIGIN? (Specify Yas	or No.		— American Indian.
	1 Never Married 2 Married		YES 2 XNC		If yes,	specify Cuba	n, Maxicar	n, Puarto Rican, etc.)	0	Black	, White, atc.
B	3XXWidowed 4 ☐ Divorced	IF YES, GIVE Y	WAR OR DATES		1 1 1	ES 2 NO	Specify	**	- 1	Spech	WHITE
	15. DECEDENT'S EDI	ICATION	16a DECI	EDENT'S HE	SUAL OCCUPA	TION	_	16b. KIND OF BUS	1	110 Tmv	MULTE
COMPLETED	(Specify only highest grad	e completed)	(Give	o kind of wor	rk done durina	most of workin	g	166. KIND OF BUS	SINE 35/IND	USTHY	
ا ت	Elementary/Secondary (0-12)	College (1-4 or 5	+)								
₹	12	3		THL	ETE			SPORT	ING/	GOL	F
Ö	17. FATHER'S NAME (First, Middle, Last)					18. MOTH	HER'S NAI	ME (First, Middle, Malden	Sumame)	1000	11.
BE (PHILIP J. ARE	INDES				TE	ESST	E SCHWAB			
	19a. INFORMANT'S NAME (Type/Print)	Color Miles	19b.	MAILING A	DDRESS (Street			loute Number, City or Tow.		Code	
2	DR. JEAN A. WI	TTTCU									WD 21502
- 1		TITCH					1 51	., CUMBE			
	20a. METHOD OF DISPOSITION 1X Burial 2 Cremation 3 Ran	noval from Stata	20b. PLACE AN	DDATE OF	DISPOSITION	(Name of		DATE 20c. LO	CATION	City or To	wn, Stata
	4 Donation 5 Other (Specify)		ROSE	HILI	CEM	ETERY	7/	22/95 CU	MBER	LAN	D, MD
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	0 1		22. NAME	AND ADDRES	SS OF FAC	CILITY			
	1 ouglas	A H	ale		HAF	ER CH	IAPE	L OF THE	HIL	LS	MORTUARY
			7		130	2 NAT	CION	AL HWY,	LA V	ALE	,MD 21502
- 1	23. PART i. Enter the disesses, or	complications the	t caused the deal	th. Do not	sntar tha i	mods of dyl	ng, such	ss cardisc or respi	ratory srr	est,	Approximate
- 1	shock, or heart fallure. List only one cause on each line. Interval Batween Onset and Dasth										
	disease or condition										
	resulting in death)		OR AS A CONSEOL			DUA					one hour
Z	Sequantially list conditions,		mer's Dis								flive years
μH	if any, leading to immediate	DUE TO	(OR AS A CONSEQU	IENCE OF):							
5	cause. Entar UNDERLYING CAUSE (Disease or injury	C.									
뜨	that initiated events	DUE TO	(OR AS A CONSEQU	ENCE OF):							
	resulting in death) LAST										
8		d									
EDICAL CERTIFICATION	PART II. Other significant condition	ns contributing to	daath but not res	sulting in	tha undariy	ing cause g	lvan in	Part I. 24e. WAS AN		24b.	WERE AUTOPSY FINDINGS
2	ASCVD							PERFOR	9 4		AVAILABLE PRIOR TO COMPLETION OF CAUSE
								t TYES 2	NO		OF DEATH?
Σ											1 YES 2 NO
ż	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEAT	H YES		UNC	ERTAIN	1 🗆		-	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE		(Check only or	10)					
SIC	1 Tes 2 NO	HOSPITAL:	ER/Outpatient 3		THER:	ome 5 □ Re	eldence	8 Other (Specify)			
}	27. MANNER OF DEATH	28a. DATE OF	/	28b. TIME (NJURY AT	alderica	28d. DESCRIBE HOW II	HILIDY OCC	HIBED	
	1 Natural 5 Pending	(Month, E	lay, Year)	INJUR	TY .	WORK?		and occombe now in	NON! OCC	ONED	
BY	2 Accident Investigation					YES 2	NO				
	3 Suicide S Could not be	28a. PLACE C building,	F INJURY — At hom- atc. (Specify)	e, farm, atro	et, factory, of	ffica	- 1	28f. LOCATION (Street a City or Town, State)	ind Number	or Rural R	oute Number,
COMPLETED	4 Homicide determined										
	29a. CERTIFIER CERTIFYING PHYS	ICIAN: To the heat of	en beautadas dad								
₽ 								to the cause(a) and man			
8	12	ER. On the basis of a	xamination and/or in	reatigation,	in my opinion	, death occur	ed at the	time, data and place, an	d due to th	Cause(a)	and manner as stated.
ш	296. SIGNATURE AND TALE OF CONTURE	H				290-LICE	NEE NUM	BER, /	29d. 9477	HIGHING	Month Day Wash of -
		Contract of the Contract	ND				1100	UI	> ('	MHYI	119, 1995
00	(VXIIII)	MANA									
TO B	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CALL	SE OF DEATH (ITEM	27) (Time D	rint)	/	0.0		-		111)1110
00	30. NAME AND ADDRESS OF PERSON WI					Chrain	DI AN	ח אות מוב	02	0	111111111111111111111111111111111111111
0	DR TERRY WILLIAM	AS MEMO	RIAL MEDI	CAL		CUMBE	RLAN	D, MD 215	02	0	111)1110
00	The second secon	AS MEMO		CAL		CUMBE	RLAN	D, MD 215	02	0) 1) 11.0



*BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATN 3. TIME OF DEATN MARION BARBER 4:04 PM AGNES July 19, 1995 A. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH
(Month, Day, Year)
Jan. 23,1909 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS HOURS 1 🗆 M 2 🖵 F 577-01-2675 86 VRS Maryland 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c COUNTY OF DEATH DIRECTOR COLLINGTON CONTINUOUS CARE FACILITY
RESIDENCE OF DECEMENT Mitchellville Prince Georges 10b. COUNTY 10c. CITY, TOWN OR LOCATION Mitchellville 10e. STATE 10d, INSIDE CITY Prince Georges 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOE 10g. CITIZEN OF WNAT COUNTRY? USA 20721 10450 Lottsford Road 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify If yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☑ NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY 3 🔀 Widowed 4 🗌 Divorced White 16a. DECEDENT'S USUAL OCCUPATION ETED 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done life, Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL C & P Telephone Company Supply Clerk 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Malden Surname) unavailable Ida McFarlane BE 19e, INFORMANT'S NAME (Type/Print) 19b MAILING ADDRESS (Street and Number of Aural Route Number, City or Town, State, Zip Code)
5356 Gainsborough Drive
Fairfax, VA 22032 2 Raymond A. Barber 20a. METNOD OF OISPOSITION
1 ☐ Burlel 2. Cremetion 3 ☐ Removal from State 20b. PLACE ANO OATE OF DISPOSITION (Name 20c. LOCATION — City or Town, State of cemetary, crematory or other place) Metropolitan Crematory 4 Donetion 5 Other (Specify) 7/21 Alexandria, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Marshall's Funeral Home, Inc. ar 4308 Suitland Road, Suitland, MD 20746 23. PARTVI. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death IMMEDIATE CAUSE (Fins) Therooderation Heart disesse or condition __resulting in death) D becar DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially flat conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AILABLE PRIOR TO EMPLETION OF CAUSE cheten 1 TYES 2 PINO OF DEATH? 1 ☐ YES 2 ☐ NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: 1 YES 2 70 g Home 5 Residence 8 Other (Specify) 4 Num 27. MANNER OF OEATH 28e. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 28b. TIME OF 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be COMPLETED 4 Homicide 29e. CERTIFIER
1 Check and 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER 29d. DATE SIONED (Morth, Day, Year) Attendit Physic O. 025 21 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MUDZ Jeobrook, Mo 20705 Executive 11. anowith. 7404

32: REGISTRAR'S SIGNATURE 31. DATE FILEO (Month, Day,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

,		1 - STATE OF I		MENT OF HEALTH AND MEATE OF DEATH	MENTAL HYGIENE REG. NO.	
		Dr. Samuel L	Bamils		2. DATE OF OEATH MONTH LINY 19 19	95 S. TIME OF DEATH
		4. SOCIAL SEGURITY NUMBER 226_34_2130 1	64 YRS. M	ONTHS DAYS HOURS MIN. Ob. CITY, TOWN OR LOCATION OF DE.	7. DINTE OF MIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country) NOTFOLK VQ r COUNTY OF DEATH
	СТОВ	PRINCE GEORGES COUNTY HO		Cheverly		ince Georges
	DIRE	10e. STATE 10b. COUNTY		town or Location anham		10d. INSIDE CITY LIMITS? 1 🖾 YES 2 🗌 NO
	NERAL	9006 Walkerton	Dr.	101. ZIP CODE 2070	6 10g.	CITIZEN OF WHAT COUNTRY? USA
	BY FUN	1 Never Married 2 1 Married FORCES? 1	IT EVER IN U.S. ARMED VES 2 □ NO NAR OR DATES	13. WAS DECENDENT OF HISPAN. If yes, specify Cuban, Mexican 1 YES 2 NO Specify.	, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
	PLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5	+) Director	k done during most of working Of Compensatory	Baltimore System	Public School
d at once.	SE COMPL	17. FATHER'S NAME (First, Middle, Last)	Funded Pr	16. MOTHER'S NAM	E (First, Middle, Meiden Surnam	10)
e notifie	TO B	190. INFORMANT'S NAME (Type/Print) Elizabeth H. Banks	19006 W Lanham	alkerton Drive	oute Number, City or Town, State,	; Zlp Code)
must b		20a METHOD OF DISPOSITION 1 A Burlel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify)	7/26 Laurel	ATION — City or Town, State		
examine		21. SIGNATURE OF FUNERAL SERVICE LICENSEE		Marshall's Fun 4308 Suitland	eral Home, In Road, Suitla	nc. and, MD 20746
or other traumatic event, the medical examiner must be notified at		23. PAT I. Entar the diseases, or complications the abock, or heart failure. List only one can IMMEDIATE CAUSE (Final disease or condition resulting in death)	ise on aach lina.	anter the mode of dying, such		Interval Between
traumatic	ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	(OR AS A CONSEQUENCE OF):			
or other	CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	(OR AS A CONSEQUENCE OF):			
65	EDICAL	PART II. Other algnificant conditions contributing to	death but not resulting in t	tha undarlying causa given in F	Part I. 24a. WAS AN AUTOP. PERFORMED? 1 YES 2 100	AMILABLE PRIOR TO
23 sl	AN: M	DID TOBACCO USE CONTRIBUTE TO CA				1 YES 2 NO
or item	잃	EXAMINER? 1 VES 2 NO 1 Inpetient 2		(Check only one) THER: Nursing Home 5 Residence 6	Other (Specify)	
marked,	ВУ РНҮ	27. MANNEB OF DEATH 1 Netural 5 Pending 2 Accident Investigation	INJURY 28b. TIME O INJURY	PF 28c, INJURY AT WORK? M 1 YES 2 NO	26d. DESCRIBE HOW INJURY	OCCURED
28 is	ЕТЕО	3 Sulcide 8 Could not be determined 26e. PLACE 0 building,	F INJURY — Al home, farm, atre- atc. (Specify)	et, fectory, offica	281. LOCATION (Street and Nurr City or Town, State)	nber or Rural Route Number,
NT: If item	COMPL	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of MEDICAL EXAMINER: On the best of a				
POR	O BE	THE SIGNATURE AND TITLE OF CERTIFIER HOME	MO	20c. LICENSE NUMI	30 24 C	DATE SIGNED (Month, Day, Year)
		AND ADDRESS OF PERSON WHO COMPLETED CAN	SE OF DEATH (ITEM 27) (Type, Pri	9 Ray pum Ct-C	p Sum.	211748

JUL 21 1995

Marching.

BALTIMORE, MARYLAND 21215-0020

PARI I, 27, 28a-f, PER MEO FILM G-726 8/10/95 t.t ITEMS: 23

REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)								OF DEATH			3. TIME OF	DEATH
	GREGORY BRANNUM July									y 15, 1995 YEAR 2:30		
4. SOCIAL SECURITY NUMBER	BER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. 0				7. DATE	OF BIRTH		0. Bit	RTNPLACE (State	or Foreign		
578-70-2052	1 M 2 D F	44 YRS. MONTHS DAYS HOURS MIN.				July	29,1	950		sh. D.C		
	FACILITY NAME (If not institution, give street and number)					ON OF D	EATH			_	F DEATH	
4100 Byers Stre	eet			Capitol	Hei	ghts	5		Pri	nce	George	5
RESIDENCE OF DECEDENT	RESIDENCE OF DECEDENT										10d. INSIDE	CITY
	e George			tol Hei							LIMITS	
10e. STREET AND NUMBER			_	I 10	t, ZIP COD	F			10a CI	TIZEN C	1 X YES	
4100 Byers Stree	at.			1 "	2074					SA	or mini occini	•••
11. MARITAL STATUS		IT EVER IN U.S. ARMED		13. WAS DEC			NIC ORIGIN	? (Specify Ye			ACE — American	Indian.
1 Never Married 2 Married	FORCES? 1	YES 2 NO		If yes, sp		ın, Maxica	in, Puerto F			B	Black, White, atc. Specify:	
3 Widowed 4 Divorced	1,720, 5.72	THE STATE OF			, 2 53 110	Орчол	,				Black	
15. DECEDENT'S ED (Specify only highest grad	UCATION to completed)	16a. DECEDE	ENT'S U	ISUAL OCCUPATI	ON . ost of work	na	16b.	KIND OF BL	ISINESS/IN	NDUSTR	TY .	
Elementary/Secondary (0-12)	College (1-4 or 5	+) life. Do A	VOT use	ork done during m retired.)								
11th		Parki	nq	Attenda				rivat			try	
17. FATNER'S NAME (First, Middle, Last)	17. FATNER'S NAME (First, Middle, Last)							Aiddle, Maide				
Ralph Brannum								emmin				
19e, INFORMANT'S NAME (Type/Print)				ADDRESS (Street								
Gwendolyn Jackso				yers St		, Ca	_					
	10s. METHOD OF DISPOSITION □ Burlel 2 □ Cremetton 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place)										or Town, State	
4 Doneston 5 Dotter (Specify) Metropolitan Crematory 7/19 Alexandria, VA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Marshall's Funeral Home, Inc.												
	ICENSEE			22 NAME A	NO ADDD	IRE OF E						
		1		Mars	nall	S F	inera	1 Hom	e, I	nc.		
▶ J. P. War. 23. PART I. Enter the diseeses, or	shall complications the	at caused the death.	Do no	Mars 4308	nall Suit	s Fi land	nera Rd.	, Suit	lanc	1, M		ximate
. J. P. mar	complicatione the List only one can	at caused the death.		Marsi 4308 ot enter the m	nall Suit	s Fi land	nera Rd.	, Suit	lanc	1, M	Appro	ximate ai Betwee
23. PART I. Enter the diseases, or shock, or heart fellure immediate cause (Finei disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. THERM. DUE TO DUE TO	at caused the death. use on each line. AL INJURIES	ICE OF)	Marsi 4308 ot enter the m	nall Suit	s Fi land	nera Rd.	, Suit	lanc	1, M	Appro	
23. PART I. Enter the diseeses, or ahock, or heart fellure iMMEDIATE CAUSE (Finei diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury	a. THERM. DUE TO DUE TO	at caused the death. use on each line. AL INJURIES O (OR AS A CONSEQUEN O (OR AS A CONSEQUEN	ICE OF)	Marsi 4308 ot enter the m	nall Suit	s Fi land	nera Rd.	, Suit	lanc	1, M	Appro	ximate ai Betwee
23. PART I. Enter the diseases, or shock, or heart fellure immediate cause (Finei disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	a. THERM. DUE TO C. DUE TO d	at caused the death. use on each line. AL INJURIES O (OR AS A CONSEQUEN O (OR AS A CONSEQUEN O (OR AS A CONSEQUEN	ICE OF	Marsi 4308 ot enter the m	nall' Suit	S Fi	nera Rd.	Suit	N AUTOPS	l, M	Appro	iximate all Betwee and Deat and Peat
23. PART I. Enter the diseases, or ahock, or heart feilure iMMEDIATE CAUSE (Finei disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE. (Disease or injury that initiated events resulting in death) LAST	a. THERM. DUE TO C. DUE TO d	at caused the death. use on each line. AL INJURIES O (OR AS A CONSEQUEN O (OR AS A CONSEQUEN O (OR AS A CONSEQUEN	ICE OF	Marsi 4308 ot enter the m	nall' Suit	S Fi	nera Rd.	, Suit	N AUTOPS	l, M	Approintery Onse/	ximate all Betwee and Deat and Deat
23. PART I. Enter the diseeses, or ahock, or heart feilure iMMEDIATE CAUSE (Finei diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions.	a. THERM. DUE TO C. DUE TO d	at caused the death. use on each line. AL INJURIES O (OR AS A CONSEQUEN O (OR AS A CONSEQUEN O (OR AS A CONSEQUEN	ICE OF	Marsi 4308 ot enter the m	nall Suit	S F1 land ling, suc	Rd.,	Suit	N AUTOPS	l, M	Approinterv Onse/ Onse/ 24b. WERE AUTO AMAILABLE F COMPLETION OF DEATH?	ximate all Between and Deat and Deat
23. PART I. Enter the diseases, or ahock, or heart feilure iMMEDIATE CAUSE (Finei disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions and the conditions is the conditions of the conditions of the cause. Examiner?	a. THERM. DUE TO DUE TO DOBE CONTRIBUTING TO	at caused the death. use on each line. AL INJURIES O (OR AS A CONSEQUEN O (OR AS A CONSEQUEN O (OR AS A CONSEQUEN O death but not result	ICE OF)	Marsi 4308 ot enter the m	nall Suit	S F1 land ling, suc	nera Rd.	Suit	N AUTOPS	l, M	Approinterv Onse/ Onse/ 24b. WERE AUTO AMAILABLE F COMPLETION OF DEATH?	ximate all Between and Deat and Deat
23. PART I. Enter the diseases, or ahock, or heart feilure immediate CAUSE (Finei disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions and conditions in the conditions in	A. THERM. DUE TO DUE TO DOBE CONTRIBUTING TO	at caused the death. use on each line. AL INJURIES O (OR AS A CONSEQUEN O (OR AS A CONSEQUEN O (OR AS A CONSEQUEN O death but not result ER/Outpetient 3 0	ICE OF)	Marsi 4308 ot enter the m	nall Suit Suit ode of dy	given in	Part I.	24a. WAS A PERFC YES	N AUTOPS	Y	24b. WERE AUTOI AMAILABLE F COMPLETION OF DEATH? 1 YES :	ximate all Between and Deat and Deat
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23. PART I. Enter the diseases, or ahock, or heart feilure immediate cause (Finei disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions and the cause of the caus	DUE TO DUE TO	at caused the death. at caused the death.	OOA TIME	Marsi 4308 ot enter the marsi 4308 ot enter the marsi 4	DACE OF TO HOLE and place	given in DEATN (C) tealdence	nera Rd., ch as cere heck only or Cly Chy CAR to the ca	24a. WAS A PERFC (XC) YES 24a. WAS A PERFC (XC) YES PERFC (XC) YES ATION (Street HOW F - I MMOI CATION (Street HOW AGE)) (AUGUS) (A	NAUTOPS PRIMED? 2 NO ATION 4 and Number of APITO Banner as a	Y Y Y Tribot of the control of th	24b. WERE AUTON ANALABLE F COMPLETION OF DEATH? 1 YES ::	eximate all Betwee and Deat Person To OF CAUSE
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23. PART I. Enter the diseases, or ahock, or heart feilure immediate cause (Finei disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions and the cause of the caus	DUE TO DUE TO	at caused the death. at caused the death.	OOA TIME	Marsi 4308 ot enter the marsi 4308 ot enter the marsi 4	DELACE OF TO HOLE and placed death occurrence of the control of the control occurrence o	given in DEATN (C) Residence NO	nera Rd., ch as cert Part I. Peck only or 6 □ Othe 28d. DE 28f. Loc City (GAR in to the ca e time, date	24a. WAS A PERFC (XC) YES 24a. WAS A PERFC (XC) YES PERFC (XC) YES ATION (Street HOW F - I MMOI CATION (Street HOW AGE)) (AUGUS) (A	N AUTOPS PRIMED? 2 INJURY C. ATION to any Minute and due to 29d. D	Y Y OCCURE DE REPORT OF THE PROPERTY OF THE	24b. WERE AUTON ANALABLE F COMPLETION OF DEATH? 1 YES ::	eximate all Between and Deat and Deat syr Findings from To Lor Cause 1 (2004)



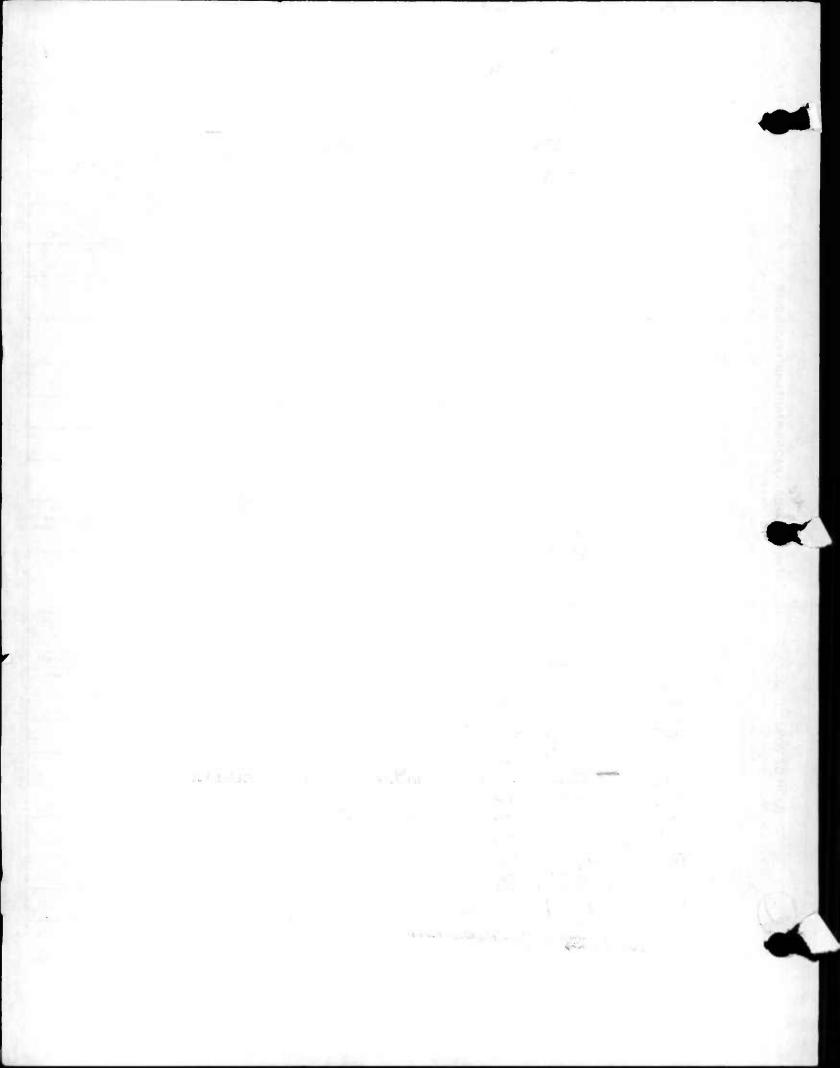
31. DATE FILED (Month, Day, Year)

JUL 21 1995

32 REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-16 Rev 1/89



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

i	1. DECEDENT'S NAME (First) GERTRUDE		BREMSER							2. DATE OF	OEATN DA	Y	YEAR	3. TIME OF DEATN
									17				72 70 27 11	
- 1			5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF I (Month, Da	ly, Your)		Count	
ŀ	99. FACILITY NAME (# not institution, give street end number)					0.000	-			June	25,			hington, DC
<u>«</u>	Prince Geo:			Contor			96. CITY, TOWN OR LOCATION OF DEATH Cheverly Prince George							
8	RESIDENCE OF DEC	CEDENT	Meuicai	Center		Cire	vell	У				PLL	nce	George S
H	10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCA	TION						10d. INSIDE CITY LIMITS?
ō	Maryland		e George	S	Be	rwyn	_	ghts						1 📉 YES 2 🗌 NO
§	7604 Villa		d				101	2074				10g. CIT		WNAT COUNTRY?
FUNERAL DIRECTOR	11. MARITAL STATUS	nova K		T EVER IN U.S. AR	MEO	40	W# C OF			IIC ORIGIN? (S	M			
=	1 Never Married 2		FORCES?	YES 2 X			II yes, sp	ecify Cube	n, Mexica	n, Puerto Rice	n, atc.)	or No -	Blac	E — Americen Indian, k, White, atc.
R	3 🔀 Widowed 4 🗌 Divo	becord					1 [] 123	Z M	ороспу				Spec	"" White
	15. OEC (Specify only	EDENT'S EDU	CATION completed)	18e. OE (G	CEOENT'S ive kind of a Do NOT us	USUAL O	CCUPATIO	ON ast of working	ng	16b. KIN	10 OF BUS	INESS/IN	DUSTRY	
ا ۲	Elementary/Secondery (0	0-12)	College (1-4 or 5	+)						Doni		Coom	~ o t ~	Hospital
COMPLET	17. FATNER'S NAME (First, M	fiddle, Last)		1 200	kkee	per		18: MOT	NED'S NAI	ME (First, Midd			ge s	nospitai
- 1	Wilson Wyn									e Weil		Surriemen		
O BE	190. INFORMANT'S NAME (Type/Print)		198	b. MAILING	ADDRES	S (Street	nd Number	or Rural F	Route Number, (City or Town	n, State, Zip	Code)	
۱ ۲	Carol A. D	otson		7	532	Cinn	abar	Ter	race	, Gait	hers	burg	, Ma	ryland 20879
	20a. METNOD OF DISPOSIT 1 Burlet 2 □ Cremetic	on 3 🗆 Reme	oval from State	20b. PLACE /	AND DATE	OF DISPOS	SITION (N	ame of	2-1-	OATE				own, State
	4 Donation 8 DOther 21. SIGNATURE OF FUNERA		ENSEE	cemetery, cre Cedar	Hill									ryland
			E, Ba	0		F	ranc	is G	asch	s Son	s Fu	nera	1 Ho	me, P.A.
														e, MD 20781
	23. PART i. Enter the d shock, or h	ilseases, or dieart failure.	complications the List only one car	it caušed tha de use on aach line	eath. Do r	not antar	the mo	da of dy	ing, suci	h as cardiac	or respl	ratory an	reat,	Approximata Intarval Batween
Ì	IMMEDIATE CAUSE (Final									Onset and Death				
ł	resulting in death) Due To (or As A consequence of):										1273			
_z			Pro	Lumon	Comm									~ 2wt
CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):													
2	cause. Enter UNDERLY CAUSE (Disease or Inju		c.	OR AS A CONSE	OUENOE O									
	that initiated events resulting in death) LAS	т	DOE TO	(OR AS A CONSEC	DUENCE U	r):								
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS													
À.	PART II. Other significa	ondition	s contributing to	death but not r	reaulting	in the ur	nderlyln	g cause (given in	Part I. 24	PERFOR		24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
EDICAL	COMPLETION OF CAUSE													
Σ														
Z	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF GEATN (Check only one)													
SIC	EXAMINER? 1 YES 2 NO													
PHYSICIAN	27. MANNER OF DEATH		28e. DATE Of (Month, L	INJURY	28b. TIM		28c. INJ			28d. DESCRI			CURED	
R		Pending Investigation	NI	A		М		YES 2	ON [Ν	/A		
		Could not be	28e, PLACE (building	OF INJURY — At ho , etc. (Specify)			tory, offic	•		281. LOCATIO City or To	N (Street a			Route Number,
COMPLETED	A Nomicide determined N/A													
7	29e. CERTIFIER (Check only one) CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated.													
5	2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(s) and menner ea stated.									i) and menner ea stated.				
H R	296. SIGNATURE AND TITLE	E OF CERTIFIE	-/ /	9-14264.	211	4000	~	29c. LICI	NSE NUM	BER		29d. OAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS O	F PERSON WN					•	200		1		- (/	1.19
	10x 1-1. Yel	blanas	on uli	7407	EX		rure	PI.	hr la	م کر ،	Scott	, J.o.	mo	20704
	31. DATE FILED (Month, Day,	9 1995	JULIA P	AR'S SIGNATURED	rdall									
			4.4											

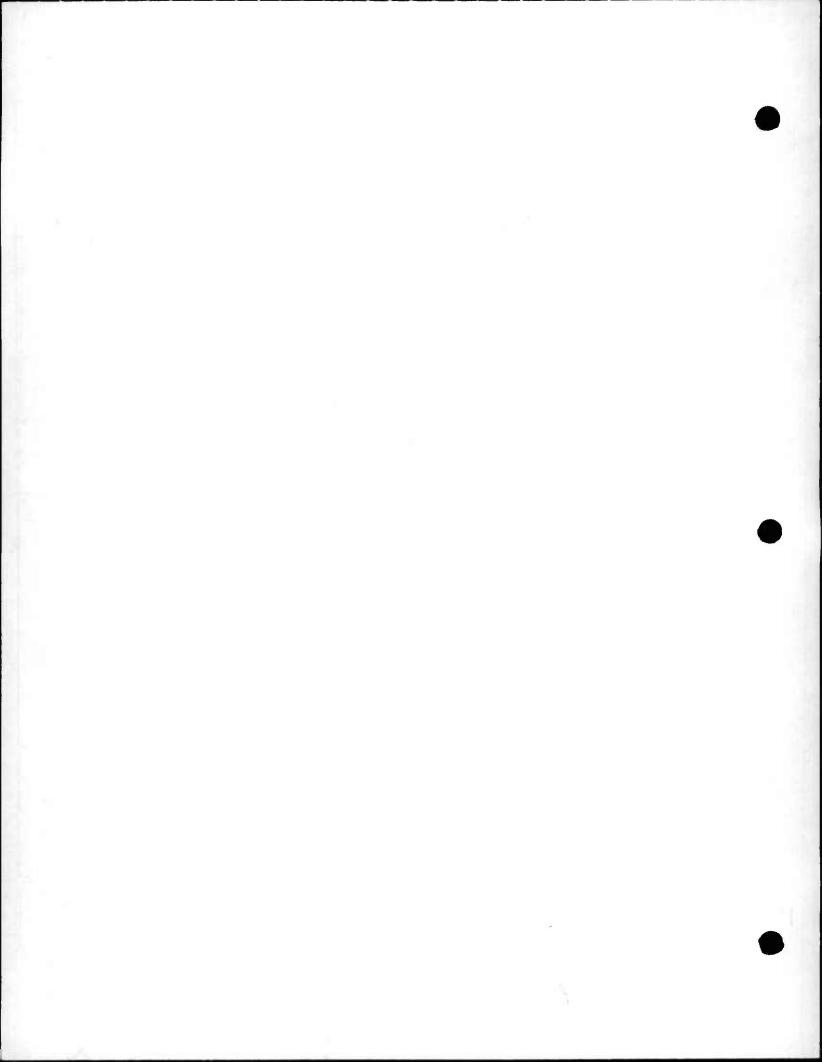
BALTIMORE, MARYLAND 21215-0020

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BALTIMORE, MARYLAND 21215-0020	the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	
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DS, P.O. BOX 68760	he death certificate be executed within 24 hours after de	
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO).					
		1. DECEDENT'S NAME (First, Middle, Las MINNIS		OE			JULY 17	71995 YEAR	3. TIME OF DEATH				
P		4. SOCIAL SECURITY NUMBER 216 40 6954		(In yrs. lest birthdey) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH	8. BIRT 1916 Colu	HPLACE (State or Foreign				
2, 3 should	TOR	99. FACILITY NAME (If not institution, give street and number) MANOR CARE, SILVER SPRING 90. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING 90. COUNTY OF DEATH MONTGOMERY											
permit, Pages 1,	DIRECTOR	PRESIDENCE OF DECEDENT 10a. STATE 10b. COUN MD. MON	TY TGOMERY	10c. CIT	Y, TOWN OR LOCA BETHESD				10d. INSIDE CITYLIMITS? 1 YES 2 NO				
Si	ERAL	100. STREET AND NUMBER 6823 BARR ROAD			10	20816		10g. CITIZEN OF					
215-0020 attending physician.	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2. NO	if yes, sp		NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) y:	Bia	In the state of th				
21 al or for u	COMPLETED	15. DECEDENT'S Et (Specify only highest gra Elementary/Secondary (0-12)	DUCATION de completed) College (1-4 or 5+)	(Give kind of life. Do NOT u		est of working	166. KIND OF BUSINESS (INDUSTRY TIONS CAN HEALTH ORGANIZATION						
MARYLAND retained by the hospit 5 should be detached notified at once.	l w l	17. FATHER'S NAME (First, Middle, Last) RUDOLPH	NEWBALL		18. MOTHER'S NAME (First, Middle, Meiden Surneme) EIMA MCLAUGHLIN								
	TO B	190. INFORMANT'S NAME (Type/Print) DAVID COE		19b. MAILING SAM	E AS 10	and Number or Rural e	Route Number, City or Tox	r Town, State, Zip Code)					
MORE, I ge 6 may be Sirector, page 5		20a. METHOD OF DISPOSITION 1	moval from Stata	PLACE AND DATE	AN CREMA	TORY JU	IY 19,1995		RIA, VA.				
BALTIMORE, nours after death. Page 6 may be of lon by the funeral director, page or removal.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY TAKOMA FUNREAL HOME INC 254 CARROLI ST N.W. WASHINGTON, D.C. 20012											
hours ed in to or red		interval Between Onset and Dast disease or condition											
P.O. BOX th certificate be ending physician J Hygiene prior to or other traur	CERTIFICATION	Sequantially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	с.	DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
F = 2 F =	OICAL	PART ii. Other algnificant condition	AUTOPSY 24 RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?									
e law has Depi	N N	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEA		UNCERTAIN	N 🗆		1 YES 2 NO				
n 2 8 5	PHYSICI,	EXAMINER? 1 AES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpatient 2 ER/Outs 28a. DATE OF INJURY	28b, TIM	E OF 28c, INJ	URY AT	6 Other (Specify) 26d. DESCRIBE HOW	INJURY OCCURED					
ATTENDING PHYS CTOR: After this c s after death with	D BY P	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	JUNE IT	(Month, Day, Veer) NUMP WORK? 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office				281. LOCATION (Street and Number or Rural Route Number.					
DIRE DIRE Hour	E	4 Homicide datarmined	Sunday, stc. (c)et	r V	Maloor	and place, and rive		att ci	try hud"				
TO THE HOSPITAL TO THE FUNERAL De filed within 72	COMPL		IER: On the basis of examination				time, data and place, as	nd due to the cause					
THE BE FINE BY THE BY T	TO BE	30. NAME AND ADDRESS OF PERSON W	Soule		Print)	Do8	546	► J W	(Month, Day, Year)				
)		31. DATE FILED (Month, Day, Year)	32, REGISTRAR'S SIGN	82		i-Scar	4 Mil	5 xx	serbado				
		111 19 1994	Falin Daveles	Karlall									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

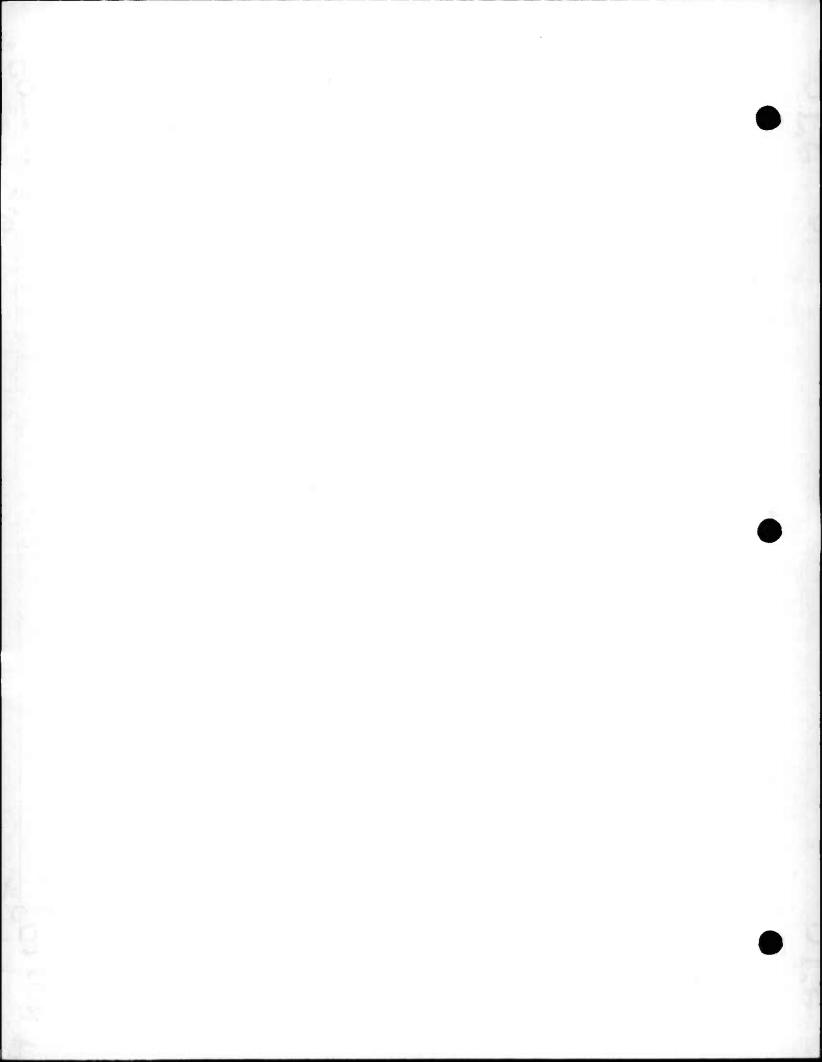
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE REGISTRAR	STATE OF MA	RYLAND /	DEPAR	TMENT OF I	IEALTH AND	MEN	ITAL HYGIENE	E			
	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH								3. TIME OF DEATH		
	Estelle		Capi	lan				uly 14,	, 1995	YEAR	8:30 P M	
	4. SOCIAL SECURITY NUMBER		L AGE (In yrs. last		IF UNDER I YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. [Month, Day, Year)		a. BIRTH	IPLACE (State or Foreign	
FUNERAL DIRECTOR	167-07-1953	1 M 2 🗗 F	95	YRS.			μu	ne 15, 1	900		P̃ennsylvania	
	9a. FACILITY NAME (If not institution, give					OR LOCATION OF D	EATH		9c. COU	NTY OF D	EATH	
	Hebrew Home of	lashingt	on	Rockv	ille			M	ontg	omery		
Æ	10a. STATE 10b. COUNT	Υ		10c. CITY	, TOWN OR LOCA	ION				10d. INSIDE CITY		
۵		gomery		E	Rockvill	e					LIMITS? 1 XYES 2 NO	
3AL	10e. STREET AND NUMBER				10	. ZIP CODE			VHAT COUNTRY?			
NE	6121 Montrose Ro					20852				SA		
5	1 Never Married 2 Merried	12. WAS DECEDENT I FORCES? 1	YES 2 -N	IED D	If yes, sp	ecify Cuban, Mexico	an, Pu	RIGIN? (Specify Yes erto Rican, atc.)	or No—	E — American Indian, c, White, atc.		
В	3 ^X Widowed 4 Divorced	IF YES, GIVE WAF	R OR DATES		1 TYES	2 NO Specif	ly:		Speci	™ White		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DEC	EDENT'S	USUAL OCCUPATION	ON at at warding		16b. KIND OF BUSI	INESS/IND	DUSTRY		
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	4		rork done during mo e retired.)	st or working						
MP	12		Hon	nema}	cer			Ho	ome :	Duti	es	
	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (F	irst, Middle, Maiden S	Sumeme)			
BE	Nathan 19a. INFORMANT'S NAME (Type/Print)	Marcusc				Bert				Ges	ner	
2	Miriam Samuels							Number, City or Town,				
	20a. METHOD OF DISPOSITION		1		F DISPOSITION (Na					City or To	um State	
	1 N Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donetion 5 ☐ Other (Specify)	ioval from State	cemetery crem	afory or of	her place)		1					
	21. SIONATURE OF FUNERAL STAYGE LICENSEE. 22. NAME AND ADDRESS OF FACILITY											
	Edward Sagel Funeral Direction											
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
	interval E iMMEDIATE CAUSE (Final disease or condition reaulting in death) DUE TO (OR AS A CONSEQUENCE OF):										intarval Between Onset and Death MANY EARS	
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): ATHEROSLE R DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	CAUSE (Disease or injury that initiated eventa reaulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):										
	PART II. Other significant conditions contributing to death but not resulting to death											
MEDICAL	PERFORMED? AVAI COM OF E										WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?	
	DID TOBACCO USE CONT	RIBUTE TO CAU	SF OF DEAT	H YE	SINON	UNCERTAIL	N F	1			1 TES 2 HO	
Ä	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				H (Check only one)	OTTOLKIAN						
Sic	1 VES 2 NO	HOSPITAL:	R/Outpatient 3	DOA	Wursing Hom	5 🗆 Residence	6 🗆	Other (Specify)				
BY PHYSICIAN:	27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28s. DATE OF INJURY WORK? M 1 YES 2 NO								OW INJURY OCCURED			
	2 Accident Investigation 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 28e. PLACE OF INJURY — At home, farm, atreet, factory, office City or Town, Stafe)										oute Number,	
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner as stated.											
H	296. SIGNATURE AND TITLE OF CERTIFIER Attending Physician 29c. LICENSE NUMBER 28d. DATE SIGNAED (MONTH, Day, Man)											
5	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE		27) (Type,	Print) TRO (F	ROR	0	CKVILI	< 1	KN	20863	
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the float. Page 6 may be retained by the hospital or attending physician.

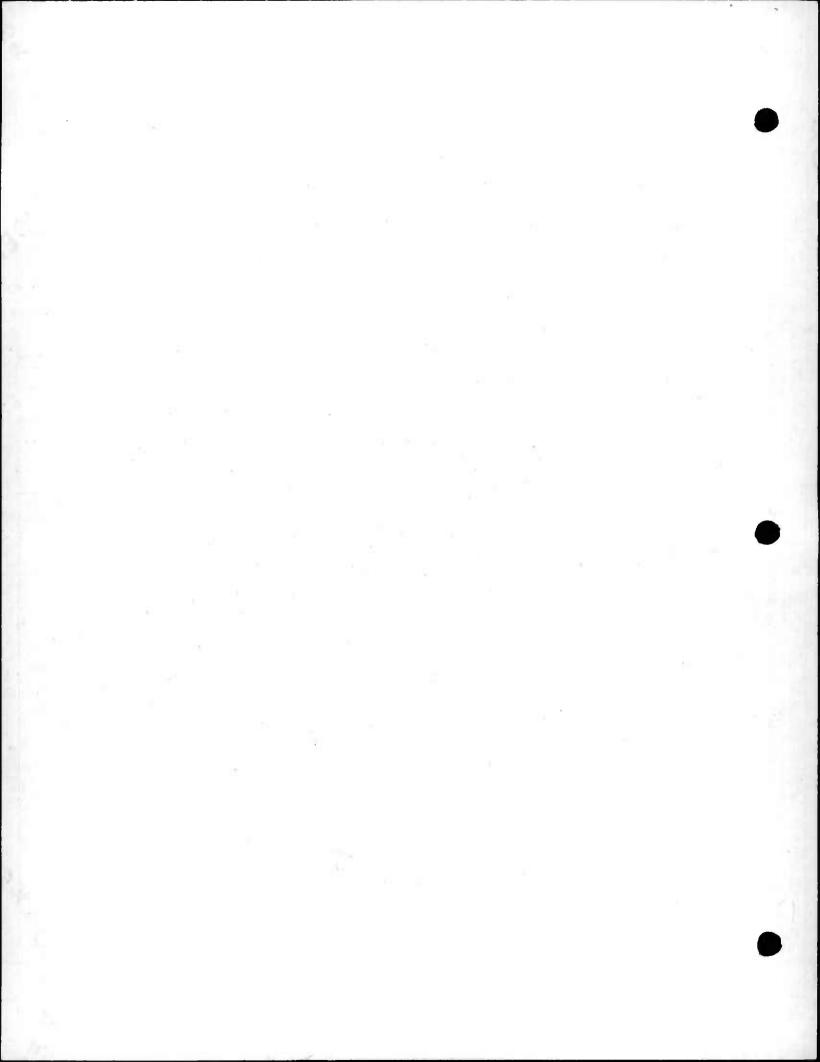
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

EDNA FRANCES CLACETT 4. SOOK SCOWNTY MANAGEM 1		HEGISTHAH			ERITE	CALE	T DEA	I FI		REG. NO.			
EDNA FRANCES CLAGETT 2. SOCIAL SECURITY MOMENTS 2. SECURITY MOMENTS 2. SECURITY MOMENTS 2. SECURITY MOMENTS 2. SECURITY MOMENTS 3. SECURITY MOMENTS		2. DATE OF DEATH										3. TIME OF DEATH	
SOLA SCOLATF MOMENTS 220—26-6438	- 88	EDNA FRAN	CES	CLAGETT	7						4.00 AM		
Secretary Secr	стов	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)			24 HRS.	7. DATE OF	BIRTH		8. BIRTH	PLACE (State or Foreign
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH HITE TO COMPLETE DR FAVA Z SHIP WAL TICOS CASTON AND TOKAMO AND TOKAMO ARTHUR TO COMPLETE AND TOKAMO AND	0				W	21.011	Dia	1-2	a	Į	1	-	10 100
	2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	E OF DEATH ITTE	27) (3pm)		1/3/3	600	/			My	17, 1775
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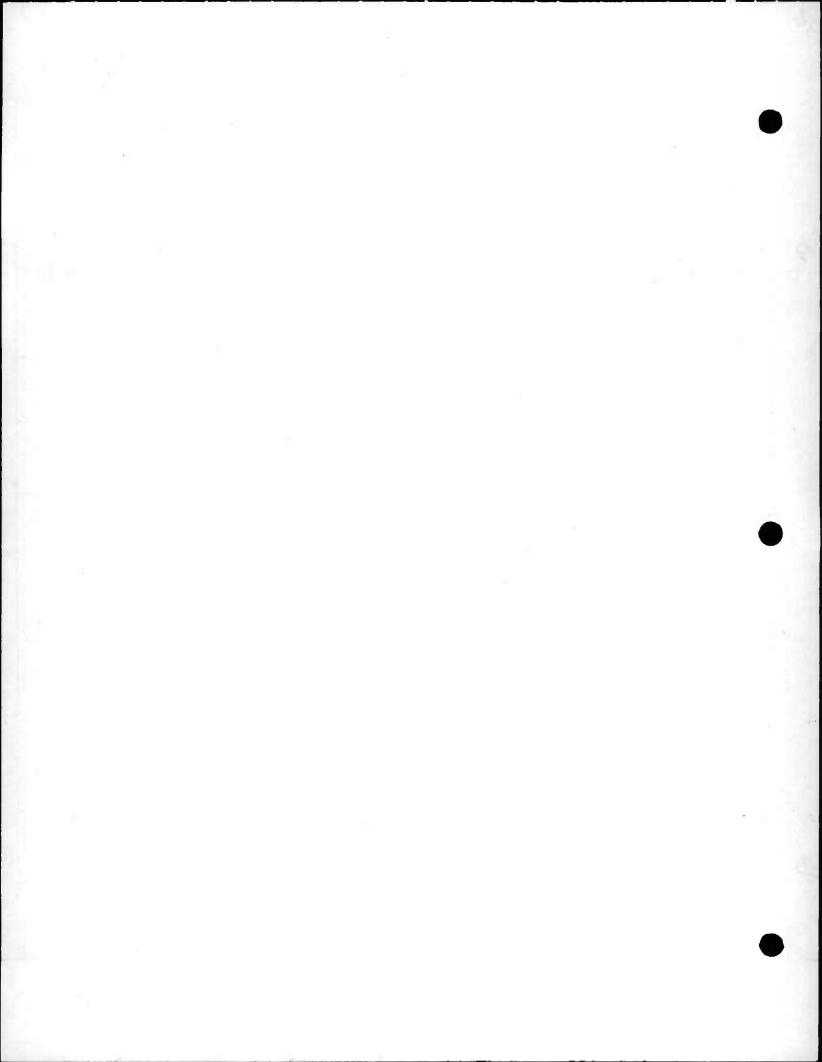


21 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH HELEN MANN CONNORS JULY 18. 5:05 P.M. 1995 4. SOCIAL SECURITY NUMBER 5 SEX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 95 HOURS 579-52-3845 1 M 2 X YRS JUNE 7. WASHINGTON.DC Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 5301 WESTBARD CIRCLE BETHESDA MONTGOMERY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY BETHESDA 1 - YES 2 X NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 20816 U.S.A. 5301 WESTBARD CIRCLE 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES X 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yes, specify Cuben, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married BΥ 3X Widowed 4 Divorced WHITE ETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 HOMEMAKER OWN HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) CLAUDIA DONALDSON ĕ ROBERT E. MANN notified 19e, INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 1 HARTMAN CT. POTOMAC, MD. 20854 DR. ROBERT M. CONNORS executed within 24 hours after death. Page 6 may be n and completely filled in by the funeral director, page 8 to burial, cremation, or removal. pe 20e. METHOO OF DISPOSITION

1 N Burlal 2 Cremation 3 Removal from State 20b. PLACE ANO DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must GATE "OF" HEAVEN CEMETERY 7/21 SILVER SPRING, MD. 4 Donation 5 Other (Specify) . examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE JOSEPH GAWLER'S SONS. INC. 0 5130 WI. AVE. N.W. WASH, D.C. 20016 medical 23. PART & Enjer the diseases, or complications that caused the deeth. Do not enter the mode of dying, such se cerdisc or respiratory arrest, Approximate shock, or haart fallure. List only one cause on each line. Interval Return IMMEDIATE CAUSE (Fine) Oneet and Death the disease or condition_ ATHEROSCLEROTIC HEART DISEASE 30 YEARS reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequantially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate the attending physician Mental Hygiene prior to e. Enter UNDERLYING CAUSE (Disease or Injury other that initiated events QUE TO (OR AS A CONSEQUENCE OF): resulting in dasth) LAST 0 PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMEO? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO signed by the any COMPLETION OF CAUSE 1 YES XX NO 1 TYES 2 T NO t, of t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO TO UNCERTAIN I PHYSICIAN: OR ATTENDING PHYSICIAN: The law I DIRECTOR: After this certificate has be hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 ☐ Nursing Home 5X Residence 8 ☐ Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED marked, 1 X Natural
2 Accident 5 Pending м 1 YES 2 NO BY Investigation 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 8 Could not be 4 Homicide 28 29a. CERTIFIER (Check only (Ch HOSPITAL FUNERAL WITHIN 72 I 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the ceuse(e) end menner se stated. TO THE HOSPIT TO THE FUNERA DE filed within 7 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE ▶ JULY 19, 1995 M D23127 6 M M 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (TEM 27) (Type, Print) KEVIN G. NEALON, M.D. 5530 WISC. AVE # 925 CHEVY CHASE, MD. 20815 31. OATE FILED (Month, Day, Year) 32 REGISTRAR'S SENATURE



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILEO (Month, Day, Year)

JUL 191995

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	1 - FOR STATE REGISTRAR	STATE OF MA	ARYLAND	/ DEPAR	RTMENT	OF H	EALTH DEAT	AND I		YGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEATH		
	PAUL	Ε.	CO	MBS, S	l m				MONTH	DA		YEAR			
	4. SOCIAL SECURITY NUMBER		B. AGE (In yrs.						JULY	9		995	2:15 A M		
	236-42-2484	1 M 2 F	74	VRS.	IF UNDER MONTHS	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF (Month, D	ey, Year)	921	Country	PLACE (State or Foreign Virginia		
	9e. FACILITY NAME (If not institution, give a	treet and number)			9b. CITY.	TOWN C	OR LOCATIO	ON OF DE		,	INTY OF DE				
DIRECTOR	Memorial Hospital						land				у				
S	10a. STATE 10b. COUNT	v		10. 07	Y, TOWN O		1.00.1	_							
<u> </u>												- 1	10d. INSIDE CITY LIMITS?		
۵	# 3.7											1 - YES 2 X NO			
A	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT CO											HAT COUNTRY?			
8	P. O. Box 65					- 1	2676	2			77 6				
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT										6.A.			
3	1 Never Married 2 Married	FORCES? 1	YES 2	NO NO	13. \	WAS DEC	ENDENT OF	F HISPAN	IIC ORIGIN? (S	pecify Yea	or No-	14. RACE Black	- American Indian, White, atc.		
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES				2 X NO			11, 410)		Specif			
	3 Wildowed 4 Divorced	W.W. II													
	15. DECEDENT'S EDU	CATION	18a. l	DECEDENT'S	USUAL OC	CUPATIO	N .		18b. KII	b. KINO OF BUSINESS/INDUSTRY					
L	(Specify only highest grade Elementary/Secondary (0-12)			(Give kind of a	work done o	during mo.	st of working	g							
7		College (1-4 or 5 +)			,				l						
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COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NA	ME (First, Midd	lle, Maiden	Sumame)				
BE (William L. Combs						0.6	а F.	Swisl	ner					
	19e. INFORMANT'S NAME (Type/Print)		1	195 MAILING	ADDRESS	/Cimat a		_	Route Number,		00-1-70	0.11			
ဥ			1												
	Jerlene N. Combs P. O. Box 65 Springfield, W. Va. 2676											6763			
	20a. METHOD OF DISPOSITION (X) Buriel 2 □ Cremation 3 □ Rem		EANDDATE		ITION (No	me of		DATE 20c. LOCATION City or Town, State							
	A Donetton 5 Other (Specify) Mt. Zion Cemetery 7-11-95 Augusta, W. V.										Va				
	21. SIGNATURE OF FUNERAL BEHVICE LINEAGE 22. NAME AND ADDRESS OF FACILITY										va.				
- 1		. 11				Miller Funeral Home P. O. Drawer 1000									
	Nas XI)	Mhu							. 26				a,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	23. PARTA. Enter the diseases, or	omplications that	caused the	death Do r	of enter	the mo	de of duir	o vuo	a a conflor	00 00001			I Assessment and		
- 1	22. PART . Exter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock or heart fallure. List only one cause on each line. Approximate interval Between														
- 1	IMMEDIATE CAUSE (Final								Onast and Death						
- 1	disease or condition	ene of right leg								3 Days					
	reaulting in death) a. Gangrene of right leg DUE TO (OR AS A CONSEQUENCE OF):											J Bays			
ᇹᅵ	Sequentially list conditions, Occlusive Peripheral Vascular Disease											10 Years			
Ēŀ	If any, leading to immediate Due 10 (OH AS A CONSEQUENCE OF):														
2	CAUSE (Disease or injury	c											1		
CERTIFICATION	that initiated events	OUE TO (O	R AS A CONS	EQUENCE OF	F):										
E	resulting in death) LAST														
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	PART II. Other aignificant condition	a contributing to d	eath but not	t reaulting i	in the un	derlying	cause gi	iven in	Part I. 24	. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS		
5	Chronic Renal H									PERFOR	MED?		AVAILABLE PRIDE TO		
<u> </u>			,						[1]	YES 2	□ NO		COMPLETION OF CAUSE DF DEATH?		
MEDICAL									_ '	•			1 TYES 2 NO		
⊴ ∣	25. WAS CASE REFERRED TO MEDICAL		26. PL	ACE OF DEAT	TH (Check o	nly one)									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DESCRIPTION OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 O NO 1 Inperferent 2 ER/Outpetfart 3 DOA 26. PLACE OF DEATH (Check only one) 27. MANUER OF BEATH 28. NUMBER OF BEATH 28. INJURY OF DEATH 28. INJURY OF DEATH 28. INJURY AT WORK? 28. INJURY AT WORK?									_						
<u>″</u> [27 MANUEL OF PEATU														
ᇤ	27. MANNER OF BEATH	28a. DATE OF IN (Month, Day,	IJURY Year)	28b. TIM INJ	E OF URY	28c. INJU WO			28d. DESCRI	BE HOW IN	JURY OC	CURED			
BY	1 Natural 5 Pending 2 Accident Investigation	, , , , , , , , , , , , , , , , , , , ,			М	1 🗌 Y		NO							
	2 Outside	28e. PLACE OF	NJURY — At I	home, farm. s	street, facto	ory, office			281. LOCATIO	N (Street =	nd Number	or Rural De	sute Number		
	4 Homicide determined	building, et	c. (Specify)		,	,, 3,,,,		- 1	City or To	wn, State)	ITUIIIDBI	- riurai mo	Addition,		
7	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of m	y knowledge, o	death occurre	ed at the tir	me, date	end place.	and dua	to the causes) and men	ner en stel	led.			
COMPLET	one) 2 MEDICAL EXAMINE												and manney on state d		
S					,, 01			- er trid	, weta and	prove, and	aue to tr	- C=USO(8)	erru merwier de stated.		
	296. SIGNATURE AND TITLE OF CENTIFIER	ķ.					29c. LICE	NSE NUM	BER	T	29d. DAT	E SIGNEO /	Month, Day, Year)		

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CUMBERLAND.

COMPLETEO CAUSE OF OEATH (ITEM 27) (Type, Print)

TRANS SIGNATURES

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mender #20a 7/19/95 988 Ollegan Co.
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 95 23324 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH KENNETH DALE CHASE SR. JULY 995 6:30 P 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)
JUNE 20, 1938 6. AGE (In yrs, lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 232-60-7490 1 [X] M 2 🗌 F NOURS WEST VA 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 14300 JARED LANE PINTO ALLEGANY RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ALLEGANY PINTO 1 - YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 14300 JARED LANE 21556 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—if yes, specify Cuban, Mexican, Puarto Rican, etc.)

1 YES 2 N NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married Specify: WHITE 3 X Widowed 4 Divorced 1956-1958 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 SPINNER CELANESE CORPORATION 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame)
PATIENCE MALONE ROBERT J. CHASE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) KENNETH DALE CHASE, JR. P.O.BOX 29 - FT. ASHBY, WV 26719 20a METHOD OF DISPOSITION
1X Burlal 2X Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata 4 Donation 5 Other (Specify) CUMBERLAND CREMATORY CUMBERLAND, MD 22. NAME AND ADDRESS OF FACILITY
FT. ASHBY FUNERAL HOME, INC.
P.O.BOX 1260-FT.ASHBY, WV 26719 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximate shock, or haart failure. List only one cause on each line. intarvai Between **IMMEDIATE CAUSE (Final** Onset and Death disesse or condition Unknown years a Chronic Obstructive Pulmonary Disease resulting in death) Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leeding to immediate cause. Entar UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in dasth) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying causa given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? Exposure to asbestos 1 YES 2 X NO Nicotine abuse 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🖾 NO 🖂 UNCERTAIN 🗆 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 - Nursing Home 5 X Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural
2 Accident 5 Pending 1 YES 2 NO 3 Sulcide 28a. PLACE OF INJURY --- At home, farm, street, factory, offica building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide datarmined 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. MEDICAL EXAMINEM: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. AGNATURE AND TITES OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIONED (Month, Day, Year)

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COMPLET E HOSPITAL O E FUNERAL D d within 72 h TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: II 9 ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Snow, M.D.-Deputy M.E.-124 W. Third St., Cumberland, MD 21502

32. REGISTRAR'S SIGNATURE Allia Ducker Randall

DHMH-16 Rev 1/89

▶ July 18,1995

15.

4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 K F 217-05-3751 85 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give etreet end number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Magnolia Gardens Nursing Home Lanham RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Prince George's Cheverly permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE page 5 should be detached for use as the burial-transit 6105 Montrose Road 20785 Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married В 1 YES 2 NO Specify. 3 🔀 Widowed 4 🗌 Divorced COMPLETED 15. DECEOENT'S EDUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) 12 Hairdresser 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Arthur Jessie Gatts notified at Emma Mary Kurtz BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Gloria J. Cooper 15490 Snowy Ridge Place, Hughesville, MD å 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must 1 X Buriel 2 Cremation 3 Removal from State funeral director, Fort Lincoln Cemetery 4 Donation 5 Other (Specify) 7/14/95 examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE hours after death. Kearles n by the fi removal. medical SA 23. PART I. Enter the diseases, Dr complications that caused the death. Do not anter the mode of dying, such as cardiac Dr respiratory arrest, and completely filled in by burial, cremation, or remo shock, or heert fallure. List only one ceuse on each line IMMEDIATE CAUSE (Final the disease or condition Respiratory Arrest resulting in death) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): Hepatic Coma traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 the attending physician of Mental Hygiene prior to If any, leading to immediate death certificate be cause. Enter UNDERLYING Metastatic Carcinoma Liver End Stage CAUSE (Diseese or Injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the MEDICAL theen signed by the pt. of Health and N that 1) Hypertension 2) cerebrovascular accident any shows PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN has be Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) certificate the State HOSPITAL: OTHER:
4 🖾 Nursing Home 5 🗆 Reeldence 6 🗀 Other (Specify) 1 YES 2 X NO Inpetient 2 - ER/Outpetient 3 - DOA 9 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? marked, 28b. TIME OF this (1 🔀 Netural 1 YES 2 NO BY After 2 Accident 28e. PLACE OF INJURY — Al home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 60 COMPLETED 8 Could not be DIRECTOR: J 4 Homicide 28 determined Hem 1 🔀 CERTIFYINO PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(e) and manner as stated. HOSPITAL FUNERAL within 72 = 2 MEDICAL EXAMINER: On TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: I on and/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and manner as stated. 296 SIGNATURE, AND TITLE OF CERTIFIE 29c. LICENSE NUMBER BE D 21883 9

36. NAME AND APDRESS OF PERSON WHO COMPLETED CAUSE OF CEATH (ITEM 27) (Type, Print)

32. PEGISTRAN'S SIGNATURE

Dr. Hema P. Yadla, M.D.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

9470 Annapolis Road, Lanham, Maryland

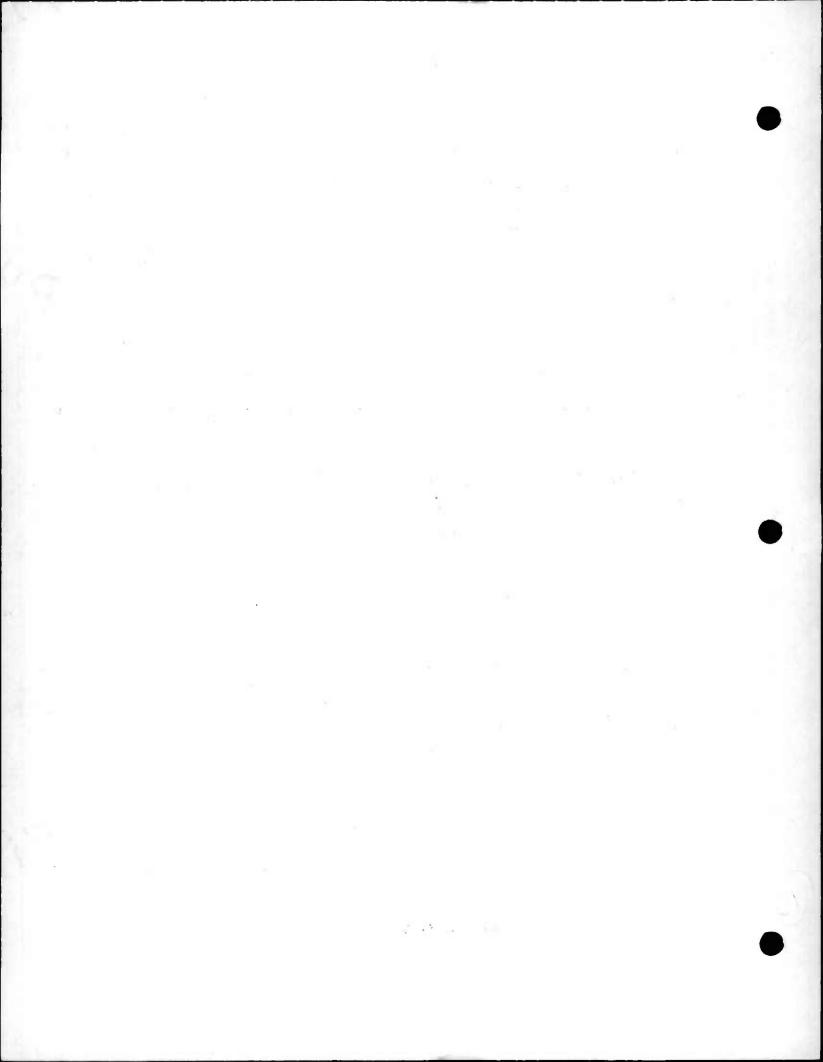
FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

OPAL LORETTA COOPER

REG. NO 2. DATE OF DEATH 3. TIME OF DEATH July 1995 10:35 A 7. DATE OF BIRTH (Month, Day, Year, April 24, 8. BIRTHPLACE (State or Foreign 1912 West Virginia 9c. COUNTY OF DEATH Prince George's 10d. INSIDE CITY 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, atc. White 16b. KINO OF BUSINESS/INOUSTRY Private 20637 20c. LOCATION - City or Town, State Brentwood, Maryland Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 Approximate Interval Between Onset and Death 1 Day 1 Week 6 Weeks 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 24s, WAS AN AUTOPSY PERFORMED? 1 TYES 2 X NO 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCUREO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) ▶ July 11, 1995

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be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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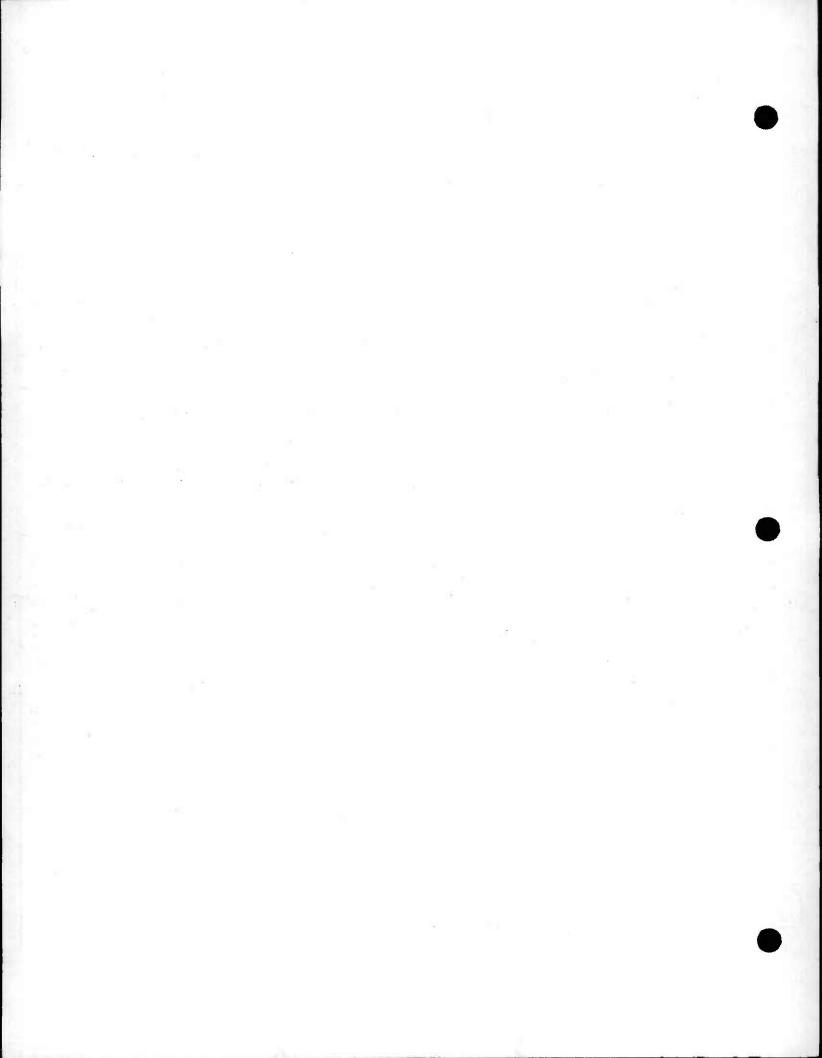
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

DECEDENT'S NAME (First, Middle, Last)

2. DATE OF DEATH

	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH													
	Joseph Spin	elli C	iccare11	i.						July	134	19	95 AR	2:10 A
	4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER	R 1 YEAR	IF UNDER	R 24 HRS.	7. DATE OF		S. BIRTI		IPLACE (State or Foreign
- 1	577-22-5886		1 📉 M 2 🗌 F	72	YRS.	MONTHS	DAYS	HOURS	MIN.		Oay, Year)	1022	Count	mington, DC
	9a. FACILITY NAME (If not in	stitution, give st	reet and number)			9b. CITY	, TOWN	OR LOCATI	ON OF DE		24,		INTY OF D	
DIRECTOR	Washington	Advent	ist Hosp	ital		Tak	oma	Park				Mon	ntgom	ery County
EG	RESIDENCE OF DEC	10b. COUNTY	,		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY			
E	Maryland	Princ	e George	1 0	Laurel							LIMITS?		
	10e. STREET AND NUMBER		c ocorge		101. ZIP CODE						10g. CITIZEN OF WHAT COUNT			
FUNERAL	11732 South	Laure	1 Drive		20708							States		
5	11. MARITAL STATUS		12. WAS DECEDEN		VER IN U.S. ARMED 13. WAS DECENDENT OF HISPANI								E — American Indian, k, White, atc.	
ВУ	1 Never Married 2 X		IF YES, OIVE Y	MAR OR DATES	NO		It yes, sp 1 🔲 YES	ecify Cube	n, Mexice Specify	n, Puerlo Ric /:	en, etc.)		Spec	
		EDENT'S EOU	1943 to								_			White
COMPLETED	(Specify on)	y highest grade	completed)	(G	ECEDENT'S Give kind of a D. Do NOT u	work done	during mo	ON ost of workli	ng	16b. K	IND OF BUS	HNESS/IN	DUSTRY	
7	Elementary/Secondary (0)-12)	College (1-4 or 5	+)			hav			Tri	10 nn	d Ma	mh 1 a	Industry
OM	17. FATHER'S NAME (First, M	liddle, Last)			Self-Employ				HER'S NA				тоте	Industry
BE C														
	19e. INFORMANT'S NAME (Type/Print) 19b. MAJLING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
٩	Bettie Ciccarelli 11732 South Laurel Drive, Laurel, Maryland 20708													and 20708
	20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of													win State
	4 Donation 5 Other (Specify) Fort Lincoln Cemetery 7/12/95 Brentwood, Maryland													Maryland
21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FORT Lincoln Funeral Home, In											Inc			
	Wards Gerbler 3401 Bladensburg Rd., Brentwood, MD 20722													
	23. PART I. Enter the diseases, or complications that caused the death. De ant enter the mode of dying, such as cardiec or respiratory arrest,													
IMMEDIATE CAUSE (Final											Interval Between Onset and Death			
	disease or condition resulting in death)	→	H	W76	10	LAV	100	IAK	x t	SI)E	MH	,		I No. As
- [THE THE COD AS A CONSEQUENCE OF													
N	Sequentially list conditions, for any leading to immediate cause. Enter UNDERLYING ACUTE DESIGNATIONS TO BE EXTUBATED DUE TO (OR AS A CONSEQUENCE OF): UNABLE TO BE EXTUBATED DUE TO (OR AS A CONSEQUENCE OF): UNABLE TO BE EXTUBATED DUE TO (OR AS A CONSEQUENCE OF): UNABLE TO BE EXTUBATED DUE TO (OR AS A CONSEQUENCE OF): UNABLE TO BE EXTUBATED DUE TO (OR AS A CONSEQUENCE OF): UNABLE TO BE EXTUBATED													
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING A TO DE TO ONTES A CONSEQUENCE OF): UNABLE TO BE EXTUBATED O DA											1 20 0 0		
FIC	CAUSE (Disease or Inju- that initieted events		DUE TO	(OH AS A CONSE	OUENCE OF	Alle	RE							went
	resulting in death) LAS	T	SFR	10										Jahr
	PART II Other elgolitics	at condition		·>										
MEDICAL	PART II. Other significe	NA C	A O 1	THM	A	in the un	iderlying	g ceuse (given in	Pert I. 2	PERFOR		24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
Ē	Calgari	ARY	A0750	2 CIMI	(1)	_				— ¦¹	YES 2	NO D		OF DEATH?
_	DID TORACCO II	SE CONITE	IDLITE TO CA	Y DIST	EASI	, D	VO F	1 11116	FDTAIL					1 TYES 2 NO
AN	DID TOBACCO U		CIBUIE TO CA		E OF DEAT			JUNC	EKIAI	<u>ч </u>				
PHYSICIAN:	EXAMINER?	1110000	HOSPITAL:			OTHER	₹:							
H	27. MANNER OF DEATH		28a, DATE OF	INJURY	28b. TIM	E OF	28c. INJ		sidence	8 Other (S		JURY OC	CURED	
ВУР		Pending Investigation	(Month, E	Pay, Year)	IŅJ	URY		PRK? YES 2 [NO					
	3 Suicide 8	Could not be	28e. PLACE C	F INJURY — At he atc. (Specify)	ome, farm, s	street, tect	ory, offic	•		28t. LOCAT	ON (Street e	nd Number	r or Rural F	loute Number,
COMPLETED	4 Homicide	determined		etc. (opecny)					Ì	City or	Town, State)			
2	290. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowledge, de	eth occurre	ed at the t	ime, dete	end place	end due	to the cause	(s) end men	ner as sta	ted.	
ĕ l) end menner es stated.
	29b. SIGNATURE AND TITLE	OF CERTIFIER	1		^			29g. LICE	NSE NUM	IBER	Т	29d. DAT	E SIGNED	(Month, Day, Year)
O BE	Anees Ahsa			1	(1)			DE	361	92		► J	ULY	7,1995
임	30. NAME AND ADDRESS OF			SE OF DEATH (ITE	M 27) (Type,	Print)				1				7,1995 ND ^{209/2}
	1610 CARA	(0 4-1	AVE.	SUITE	38	0	(A	KON	MAI	AKI	5/N/	4Ry	LA	ND
	31. DATE FILED (Month, Day,	7 1995	32. JEGISTR	R'S SIGNATURE	Nell									



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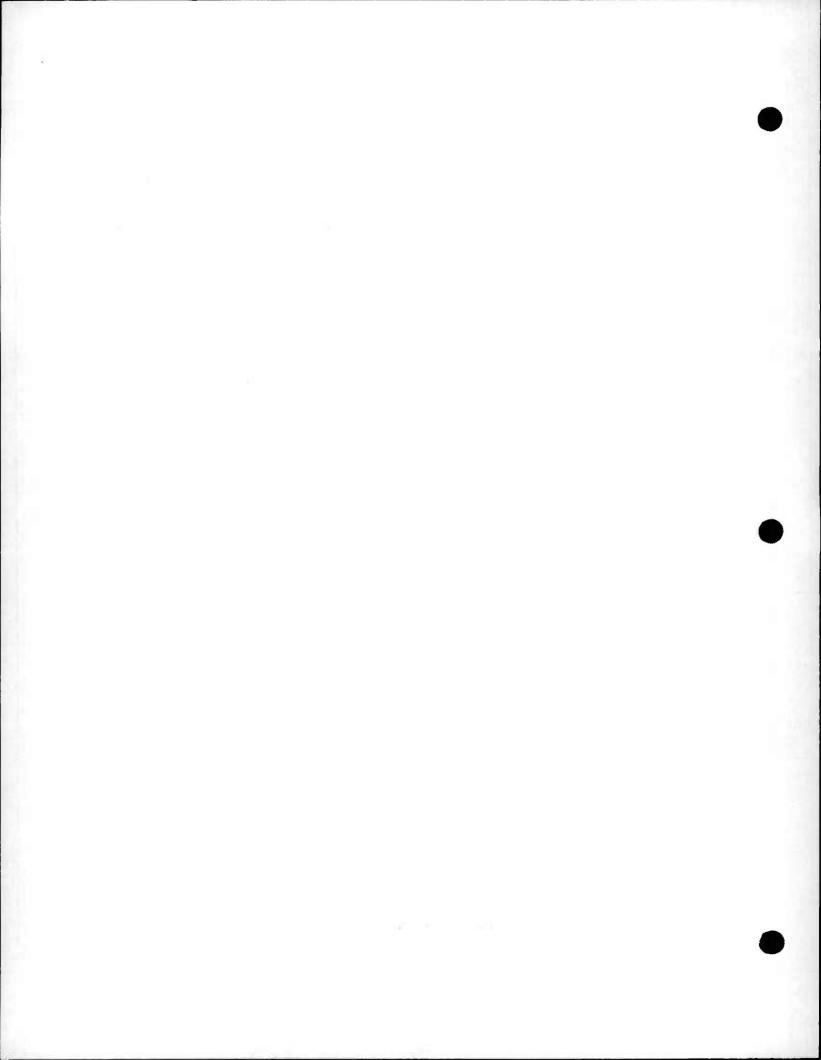
30. NAME AND ADDRESS OF PERSON

Dr. D.K. Joshi, N 31. DATE FILED (Month, Day, Year) JUL 19 1995

6525 Belcrest F

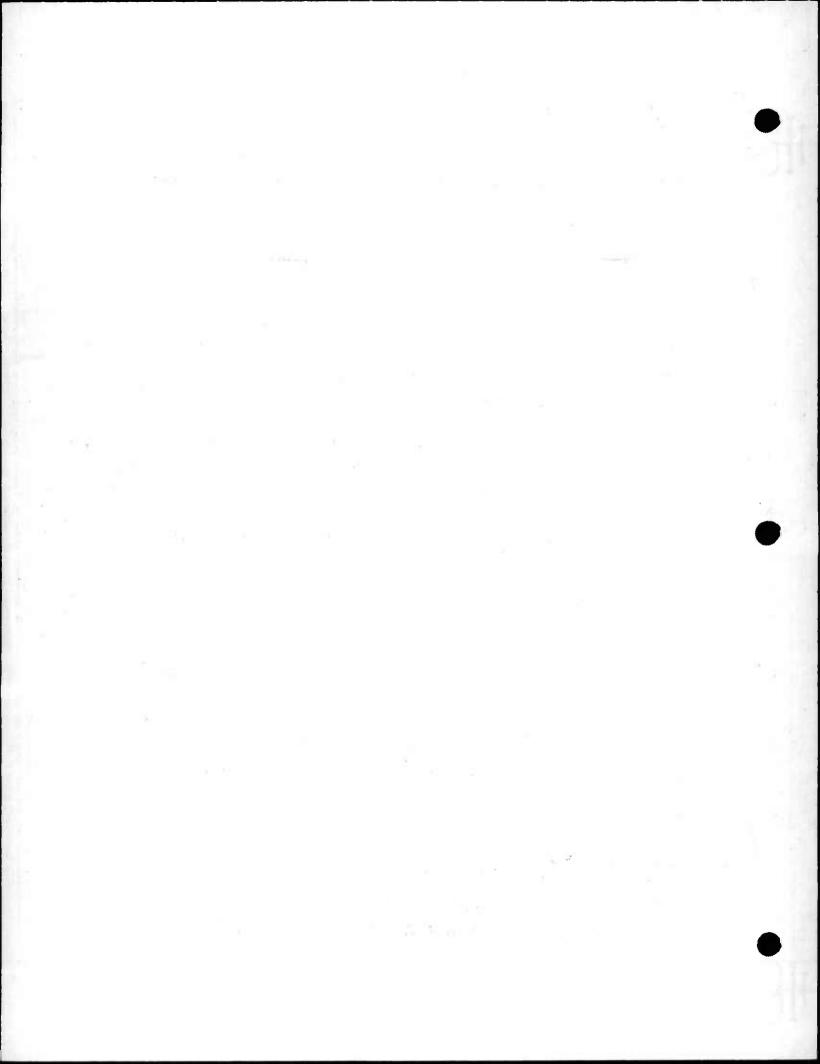
										9	5 2	2332	7
	1 - FOR STATE REGISTRAR	STATE OF N					HEALTH AND	MENTA	L HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE	OF DEATH		YEAR :	. TIME OF DEA	ATH
		SHERMAN	HB CLA	RK				Ju]		_	1995	3:40	A.Mw
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER	1 YEAR	IF UNDER 24 HRS.	(Mont	OF BIRTH		8. BIRTHPI Country)	LACE (State or F	Foreign
	723-18-7997	1 XM 2 F	62	YRS.	MONTHS	DATS	HOURS WIN.	JAN	22,19	933		INIA	
-	9e. FACILITY NAME (If not institution, give s						OR LOCATION OF	DEATH		9c. COU	NTY OF DEA	ТН	
2	12055 BEltsville	Drive			Be1	tsv	ille			Pri	nce G	eorges	3
E C	10e. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN O	R LOCA	TION				1.	0d. INSIDE CIT	v
DIRECTOR	Maryland Princ	ce George	S	Bel	tsvi	11e						LIMITS?	
A P	10e. STREET AND NUMBER					10	1. ZIP CODE			10g. CIT		AT COUNTRY?	
FUNERAL	12055 Beltsville	Drive					20705			Uni	ted S	tates	
5	11. MARITAL STATUS	12. WAS DECEDEN			13. \	MAS DEC	CENDENT OF HISP	ANIC ORIGI	17 (Specify Yes	or No-	14. RACE -	- American Ind	den,
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE W	X YES 2 1	NO	;	t yes, sp	ecify Cuban, Mexic 2 X NO Spec		Rican, atc.)		Black, Specify:		
1 1 1334 - 1331 1 1 Klack													
	15. DECEDENT'S EDU (Specify only highest grade	cation completed)	(G	ive kind of	USUAL OC	CUPATIO	ON ost of working	166	. KIND OF BU	SINESS/INC	DUSTRY		
Elementary/Secondary (0-12) College (1-4 or 5+) 4 Bus Operator Retired Public Transportation													
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 4 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bus Operator Retired 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surmame)										sport	ation		
BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street a	and Number or Rura			n Ctata 76	Code1		
2	Angela Clark	(wife)					ille Dri				,	0705	
	20s. METHOD OF DISPOSITION		20b. PLACE	AND DATE	OF DISPOS	TION /No	ame of	DAT			City or Town		
	1 Donation 5 Other (Specify)	oval from State	MD S	matory or o	ther place) ERAN	S CE	EMETERY	7/2	O CHE	ELTEN	HAM.	MARYLA	ND
1 1	21. SIGNATURE OF PUNERAL SERVICE OF	CENSEE	1		22. 1	NAME A	ND ADDRESS OF F	ACILITY					LAVE .
M859 ALEXANDER S. POPE FUNERAL HOMES 5538 Marlboro Pike, Forestville, Md 2074											. 		
\vdash	23. PART I. Enter the diseases, or	complications that	caused the de	eth. Do i	ont enter	338	Maribor	O PIK	te, For	estv	ille,		
	23. PART I. Enter the diseases, or complications that causes the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert failure. List only one cause on each line. IMMEDIATE CAUSE (Final												
	disease or condition	CANCE	R OF LUI	TC.									
1 1	resulting in death)	W	OR AS A CONSE		F):							1 1 2 1	ears
z												İ	
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	OR AS A CONSE	DUENCE O	F):							1	
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	c											
E	that initiated events resulting in deeth) LAST	DUE TO	OR AS A CONSEC	DUENCE O	F):								
E	To soming in deedily Exist	d										-	
	PART ii. Other aignificant condition	a contributing to	deeth but not r	esulting	in the un	derlying	g cause given in	Part I.	24e. WAS AN	AUTOPSY	24b, W	ERE AUTOPSY F	FINDINGS
MEDICA									PERFOR			WAILABLE PRIOR OMPLETION OF	
밀								_	1 YES 2	NV NO		F DEATH?	
	DID TOBACCO USE CONTI	RIBUTE TO CAI	USE OF DEA	TH YE	SIL	NO [UNCERTA	NΠ				YES 2	NO
NA I	25. WAS CASE REFERRED TO MEDICAL				TH (Check o		- OTTGER()						
Sic	EXAMINER? 1 YES 2 XNO	HOSPITAL:	ER/Outpetient 3	□ DOA	OTHER	l: Ine Hom	e 5 XResidence	8 🖂 Othe	e (Spacify)				
PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF (Month, Da		28b. TIM	E OF	28c. INJ	URY AT	7	CRIBE HOW I	NJURY OC	CURED		
ВУБ	1 Netural 5 Pending 2 Accident Investigation	(MORRI, Da	ty, resur	"	URY		YES 2 NO						
1 10	3 Suicide 8 Could not be	28e. PLACE Of building.	INJURY - At ho	me, term, s	treet, tecto	ory, office	•	281. LOC	ATION (Street a	nd Number	or Rural Rou	te Number,	
COMPLETED	4 Homicide distermined building, stc. (Specify)												
17	29a. CERTIFIER (Check only 1 CERTIFYINO PHYSI	CIAN: To the best of	my knowledge, de	ath occum	ed at the ti	me, date	end place, end du	s to the cau	rse(s) and man	ner es atal	led,		
8	one) 2 MEDICAL EXAMINE											nd menner es :	stated.
ш	29b. SIGNATURE AND TOTAL OF CENTIFIE	1 1	10				29c. LICENSE NU	IMBER		29d. DAT	E SIGNED (M	lonth, Day, Year))
0 8	Dufo	she /	94			[D 174	34		▶ J	uly 1	8, 199	5

Road, Hyattsville, Md



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a divulenche



THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

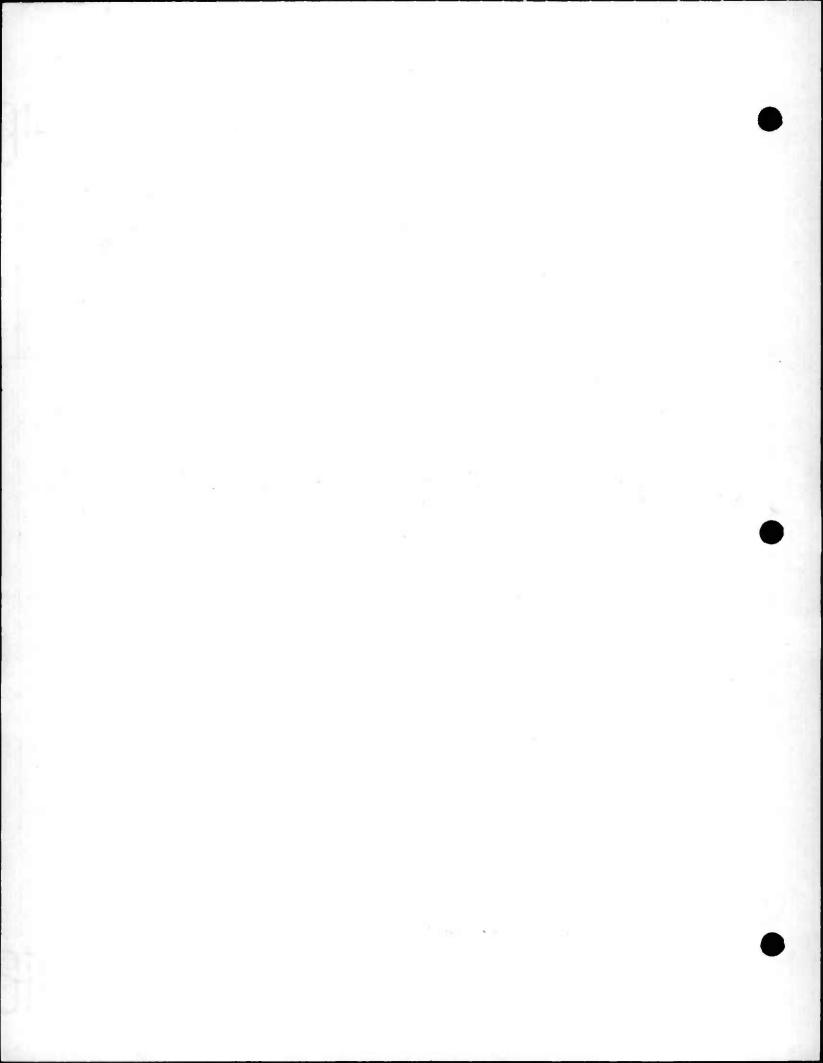
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

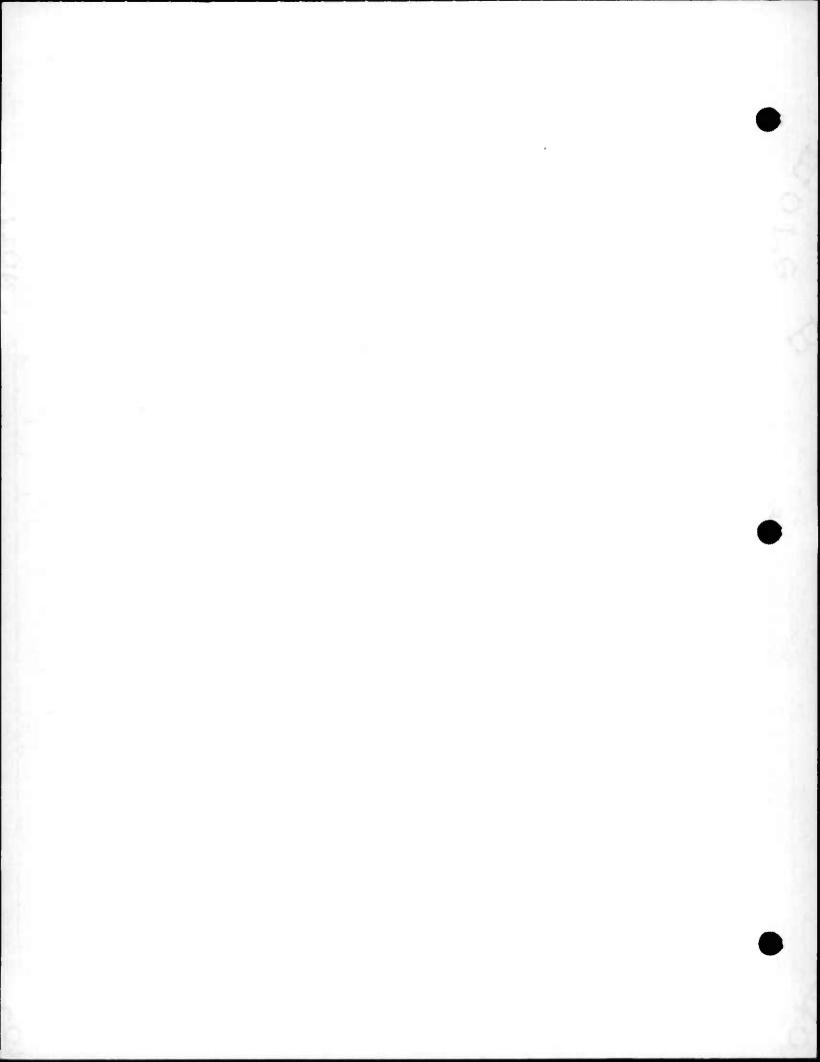
1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH												
	WILLYE		(CARTER						JULY 17, 1995			7 15P *
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	199	9. BIRT	HPLACE (State or Foreign
	229-20-485	0	1 🗌 M 2 💢 F	78	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) April 22,	1917	Vir	
	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY	, TOWN	OR LOCATI	ON OF DE			INTY OF	
OR	Prince Geo		Hospital			Cheverly						ince	George's
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY	,		10c CIT	10c. CITY, TOWN OR LOCATION							
HO	Maryland	Princ	e George	1.0	Bladensburg						10d. INSIDE CITY LIMITS?		
7	10e. STREET AND NUMBER	TTTHE	e George	5	10t. ZIP CODE						1 X YES 2 10g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	5999 Emers	on Str	eet #210		20710							5.A.	
5	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.S. ARI	IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC C					IC ORIGIN? (Specify Yes		14. RAC	E — American Indian,
BY F	1 Never Married 2 3 Widowed 4 0 Divo		IF YES, GIVE V	YES 2 N	If yes, specify Cuben, Mexican, Puerto Rican, etc.] 1 YES 2 NO Specify:							Spec	k, writte, stc.
		EDENT'S EDUC	CATION	1									White
COMPLETED	(Specify only	completed)	Work done of retired.)	CCUPATIO	on st of working	ng	16b. KIND OF BUS	INESS/IN	DUSTRY				
PLE	Elementary/Secondary (0-12) College (1-4 or 5+) 8 Clerical University										o f W	(a1	
Ö	17. FATHER'S NAME (First, M	iddle, Last)		1 010	TICA	т		18. MOTI	HER'S NAI	ME (First, Middle, Maiden		OI P.	laryland
BE C	William W. Collins Helena Torbert												
TO B	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
F	S. Melvin Carter 3066 Geronimo Avenue, Simi Valley, California 93063												
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of												
	Parklawn Memorial Park 07/20/95 Hampton, Virginia												
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A.											me. P.A.		
	4739 Baltimore Ave., Hyattsville, MD 20781												
23. PART. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between	
	IMMEDIATE CAUSE (Fin	el	•			1							Onset and Death
	disease or condition resulting in deeth) a. Cerebro Vasue la Ace Ment DUE TO (OR AS A CONSEQUENCE OF):												
	DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions, Due to (ORAS A CONSEQUENCE OF): 30 days												
SAT	in enty, reading to miniediate												1540,
Ĕ	CAUSE (Disease or injury thet initiated events Due TO (OR AS A CONSEQUENCE OF):												
ERI	resulting in death) LAST d. Hyperfens in 30 yrs												
	PART II. Other eignifice	nt conditions	s contributing to	deeth but not re	euiting i	n the un	derlying	ceuee c	iven in i	Part I. 24a. WAS AN	AUTOPSY	245	. WERE AUTOPSY FINDINGS
MEDICAL	Anence									PERFOR	MED?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE
	Aspir	atr	aneu	ch day.	,	47	-/			1 □ YES 2	NO		OF DEATH?
-	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DEAT	ГН ҮЕ	S 🗆 1	NO/IZ	UNC	ERTAIN			1	
S	25. WAS CASE REFERRED TO EXAMINER?				E OF DEAT	H (Check	only one)						
PHYSICIAN:	1 TYES 2 NO		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		• 5 □ Re	sidence (6 Other (Specify)			
표	27. MANNER OF DEATH Natural 5	Pending	28a. DATE DF (Month, D		28b. TIM	URY	28c. (NJI WO	URY AT RK?		28d. DESCRIBE HOW IN	JURY OC	CURED	
BY		investigation	7-17	-45	7:11	PH		ES 2] NO				
8		Could not be determined	28a. PLACE O building,	F INJURY — At hone etc. (Specify)	ne, term, a	rtreet, fact	ory, offici			28t. LOCATION (Street e. City or Town, Stete)	nd Number	or Rurel i	Route Number,
COMPLETED	29a, CERTIFIER							_					
MPI	(Check only									to the cause(s) end men			and the second second
8	MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, date end pieca, end due to the ceuse(s) and menner as attated.												
B	296. SIGNATURE AND TITLE	OF CENTIFIEN	200 cm	KIAN,	VICA	ean	nu		NSE NUM	BER	29d. DAT	E SIGNED	(Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CALL	SE OF DEATH (ITEM	27) (Tune	Print)		D34	122		1	_/	0-91
	Vicken Poor						Road	, B1	aden	sburg, Mar	v1an	d 20	710-2213
ı	31. DATE FILED (Month, Day,	Year)	32. BEGISTRA	R'S SIGNATURE				,		, nar	J Luii	20	. 10 2213
	JUL 1	9 1995	Jahra	indiar la	Nell								



		FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF I	HEALTH AND	MENTAL HYGIEN							
		1. DECEDENT'S NAME (First, Middle, Last)	·				2. DATE OF DEATH	DAY YEA	3. TIME OF DEATH					
			lliam I.	Danie:			July 18,	, 1995	3:22 р. м					
pin		4. SOCIAL SECURITY NUMBER 181-18-8573	1⊠M2□F 73	(In yrs. last birthday) YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	Feb. 12,	1922	ORTHPLACE (State or Foreign Country) Penn.					
2, 3 should	TOR	9a. FACILITY NAME (If not institution, give Montgomery Gene		:al		or location of or lney	EATH	9c. COUNTY O	of death TGOMERY					
-	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	TY	10c. Cl	TY, TOWN OR LOCA	ATION			10d. INSIDE CITY					
permit. Pages	AL DIR	Maryland Mon	tgomery		ockvill				LIMITS?					
. set	ERA	15317 Basswood	Court			20853	3		of what country?					
DENSICIAN.	FUNER	11. MARITAL STATUS	12. WAS DECEOENT EVER IN	N U.S. ARMED	13. WAS DEC	CENOENT OF HISPAN	NIC ORIGIN? (Specify Ye	ea or No- 14. F	RACE — American Indien,					
	BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 X YES IF YES, GIVE WAR OR DA	2 NO ATES	If yes, sp	pecify Cuban, Maxica S 2 X NO Specify	an, Puerio Rican, atc.)	A SALIDA	Black, Whita, atc. Specify: White					
r atte	필	15. DECEDENT'S ED. (Specify only highest grad	UCATION de completed)	(Give kind of	S USUAL OCCUPATION Work done during mo	ION ost of working	18b. KIND OF BL	USINESS/INOUSTF	RY					
pital o	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+) 4 yrs	life. Do NOT u	use retired.)	Consulta	mr.	- A- 7-C	sociation					
the hospital detached fo	OM	17. FATHER'S NAME (First, Middle, Last)	4 177	Planay	ement c		AME (First, Middle, Meider		30Clation					
8 6 6 C	I iii I	Irvin Daniels	S				cvena Tat							
retained 5 should		19a. INFORMANT'S NAME (Type/Print)				end Number or Rural I	Route Number, City or Tov							
ay be ret page 5 s	F	Doris R. Danie					irt, Rock	ville,	MD 20853					
e 6 m rector.		20a. METHOD OF DISPOSITION 1 Burial XIXCremation 3 Ran 4 Donation 5 Other (Specify)	noval from State 20b	PLACE AND OATE		remator	y7/20 A		dria, VA					
		21. SIGNATURE OF FUNERAL SERVICE LI		1/2			VERAL HOM							
4 0		Jeage 1	(Mon	DOU	ROCK	VILLE,	MD 2085		7.					
recuted within Z4 hours after and completely filled in by the burial, cremation, or removal after event, the medical	N	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdisc or reepiratory errest, shock, or least feiture. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Oue To (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Sequentially list condition.												
th certificate be extending physician all Hygiene prior to	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.												
The day	AL C	PART ii. Other significent condition		ut not recuiting	In the underlying	g ceuse given in			24b. WERE AUTOPSY FINDINGS					
s that need by airth any	DIC	Hyperte	usin				PERFO		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
law requires the as been signed bept. of Health 23 shows an	MEDIC								1 YES 2 NO					
	ż	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL					NO							
N: The icate has State D	SICIA	EXAMINER?	HOSPITAL: ;		OTHER:									
SICIAN certifi h the	È	27. MANNER OF DEATH	1 Inpatient 2 ER/Outp	28b. TIM	WE OF 28c. INJ	ne 5 🗆 Rasidence	8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCURE	0					
NG PHYS fter this c eath with	2	1 Netural 5 Pending	(Month, Day, Year)		JURY WO	YES 2 NO	200. 02.0002	moon coon.	í l					
CTOR: A after da after da 18	TED B	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Speci	— At home, farm, :	atreet, fectory, offic	:•	281. LOCATION (Street City or Town, State,	and Number or Ru	val Route Number,					
TAL OR AL DIRI	COMPLE		SICIAN: To the best of my knowle						se(a) and manner as stated.					
E FUNEF d within	ECC	294 SIGNATURE AND TITLE OF CENTIFIE				29c. LICENSE NUM								
TO THE HOSPI TO THE FUNER be filed within	Δ	All the	Int.	MBER 29d. DATE SIGNED (Month, Day, Year)										
1	5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN A. REUS (WIND) 15215 SHADY GROVE ADELLYING, MID 20055												
7		31. DATE FILED (Month, Day, Year) JUL 2.1 1995	32. REGISTRAR'S SIGN		70	2042010	<u> </u>	000	30					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withing the after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR AT	TO THE FUNERAL DIRECT	be filed within 72 hours a	IMPORTANT: If Item 2

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH James Randolph Dunnavant July 18 1995 5:30 A 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Ybar)
Sept. 20, 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 X M 2 F 578-24-7280 69 YRS 1925 Missouri 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 8504 Horseshoe Lane Potomac Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Potomac 1 TES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8504 Horseshoe Lane 20854 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 □ NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 N Merried If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: BY 3 Widowed 4 Divorced World War II White COMPLETED 15. DECEDENT'S EOUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Executive Insurance 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James Randolph Dunnavant Rena Daniels BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Patricia B. Dunnavant 8504 Horseshoe Lane Potomac, MD 20854 20a. METHOD OF DISPOSITION
1 Burlat 2 X Cremation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Repretery, cremetory or other place)
Mount Comfort Crematory 4 Donation 5 Other (Specify) 7/19 Alexandria, Virginia 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W. Washington, D.C. 20016 ear Levo 23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Death disesse or condition e. MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF): resulting in death) HYPOGLYCEMIA CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediata cause. Enter UNDERLYING DIABETES MELLITUS CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evants resulting in deeth) LAST PART II. Other significant conditions contributing to daeth but not resulting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO XX UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 🗆 Inpatient 2 🗆 ER/Outpetient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1XX Natural 5 Pending м 1 YES 2 NO BY 2 Accident
3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 8 Could not be COMPLETED 4 Homicide determined 29e. CERTIFIER
1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner se stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the ceuse(e) end menner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

D39966

6111 Executive Boulevard

2

2MME

DR. HAMMETT

31. DATE FILED-(Month, Pay, Year)

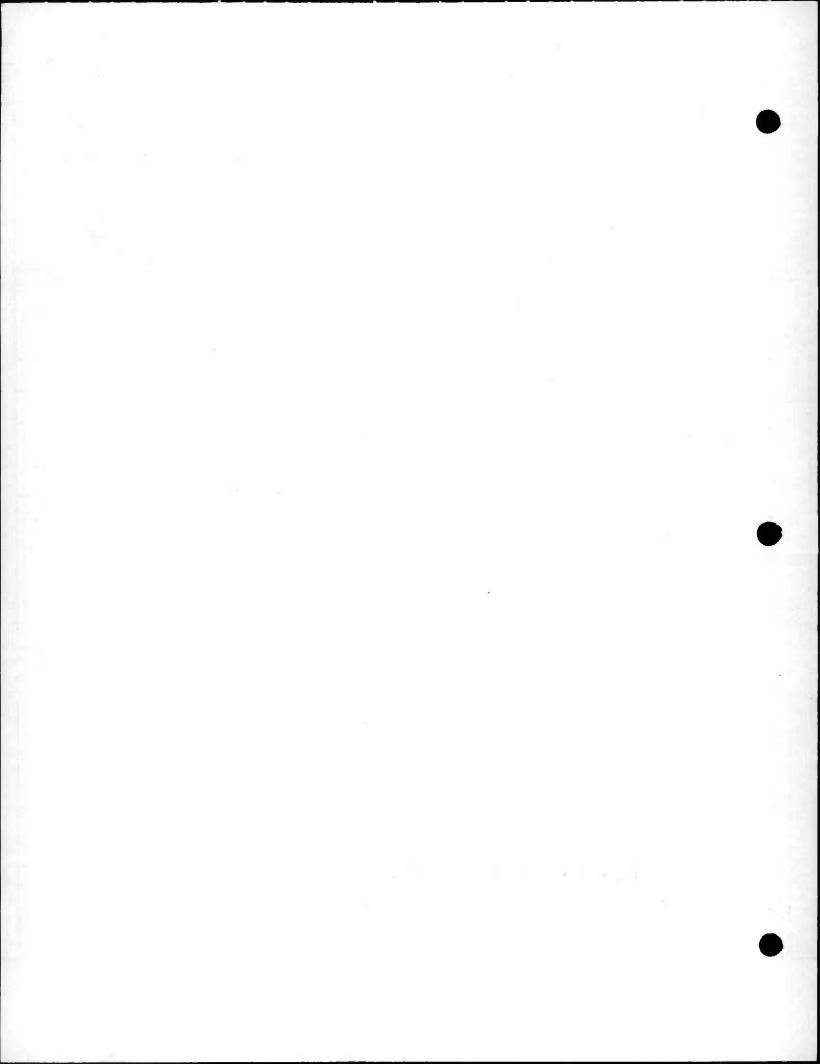
JUL 19 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S SIGNATURE Julia Davides Ro

▶ July 18, 1995

Rockville, MD 20852



28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

28d. DESCRIBE HOW INJURY OCCURED

> Approximate intarvai Batween Onaet and Death 4 mos.

8:38 8. BIRTHPLACE (State or Foreign 922 NORTH CAROLINA

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BE COMPLETED BY FUNERAL DIRECTOR

9

is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitied at once.

PHYSICIAN: MEDICAL CERTIFICATION

ВУ

COMPLETED

BE

2

IMPORTANT: If item 28

27. MANNER OF DEATH

5 Pending Investigation

8 Could not be

1 Nstural

2 Accident

3 Suicide

4 Nomicide

29e. CERTIFIER

FOR STATE REGISTRAR		STATE OF I	MARYLAND	/ DEPAR	RTMENT	T OF H	IEALTH DEAT	AND I	MENTA	L HYG					
1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE	OF DEAT		_		3. TIME O	E DEATH
PAUL	EMMETT		DEN	NY					MONT	H	DAY		YEAR		
4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER	IF UNDER 1 YEAR IF UNDER 24			July 17, 1			199		8:38	P te or Foreign
237-20-0919	9	1 🖾 M 2 🗆 F	73	YRS.	MONTHS	DAYS	YS HOURS MIN.		(Mon	th, Day. Yo	ar)	1	Countr	y)	
9s. FACILITY NAME (If not in:		treet and number)	_ / 3	9b. CITY, TOWN OR LOCATION OF DEATN						L 10		C. COUNT			ROLI
5101 River	Road					thes		01 01			- "			nerv	
RESIDENCE OF DEC	EDENT												-00.		
10s. STATE	10b. COUNTY	Υ		10c. CIT	Y, TOWN C	OR LOCAT	ION							10d. INSID	E CITY
MARYLAND	MONT	GOMERY		BET	HESD.	A							ď	LIMIT	\$? 2 📉 NO
10e. STREET AND NUMBER							ZIP CODE	E			T 10	a. CITIZI	EN OF W	HAT COUN	
5101 RIVER	ROAD	APT # 200	6				2081	6				J.S.			
11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.	ARMED	13.	WAS DEC	ENDENT C	F NISPAN	IIC ORIGI	N? (Specif	V Ves or P		_	- America	n Indian
1 Never Married 2		IF YES, GIVE V	YES 2 WAR OR DATES			If yes, sp	ecify Cubs	n, Mexica	n, Puerto	Ricen, ato	2.)			— America , Whits, sto	·
3 Widowed 4 Divo		ND KORE	A		- 163	A NO	Specif	γ.				Specif WHI.			
15. DECI (Specify only	EDENT'S EDU	CATION completed)		DECEDENT'S	work done i	CCUPATIO	ON st of workin	v7	168	. KIND OI	F BUSINE	SS/INDU	STRY		
(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +)															
		4	BA	BANKER						COMMERCIAL BANKING					
17. FATHER'S NAME (First, Mi	ddle, Last)						18. MOTH	VER'S NA	ME (First,						
ROBERT O. D	ENNY						MIN								
19s. INFORMANT'S NAME (Ty	pe/Print)			19b. MAILING	ADDRESS	(Street e			Route Num	ber Cify o	r Town St	ata Zin C	inde)		
JOAN DENNY				5101										1916	
20a. METNOD OF DISPOSITA	QN	view and the manuscriptor		EAND DATE				11 2	DAT		c. LOCATI				
1 N Buriet 2 Cremation 4 Donation 5 M Other	Specify)	ovel from State	ARI.T	NGTON	thar placa)	TONA	I CE	ΜF	1					13690	
21. SIGNATURE OF FUNERAL	SERVICE OC	ENSEE	THULL	HOTON			H ACCA		17/	24 B	TMO	IGTO	IV,	/A.	
· Lei	non	Sin	mo	NS	/ 51	130	WI.	AVE.	N.W	. WA	SHIN	[GTO).C.	20016
23. PART I. Enter the dis	seases, or c	omplications the List only one cau	t caused the	death. Do r	not enter	the mo	de of dyl	ng, aucl	n aa can	flac or r	espirato	ry arrea	nt,		roximate
IMMEDIATE CAUSE (Fin		cial only one cau	SC ON SECUL	riei.											val Batwe
disease or condition resulting in death)	→	Congest	ive he	art f	ailuı	re								1	mos.
resulting in Gentily			(OR AS A CONS											+	mos.
		Chronic	obstr	uctiv	e nul	1 mon	arv (dica	250					10	
Sequentially list condition if any, leading to immed		DUE TO	OR AS A CONS	EOUENCE OF):):	LINOIL	ary (u I S C	ase			-		10	yrs.
cause. Enter UNDERLYIP	VG													ĺ	
CAUSE (Disease or injurthat initiated events	y Y	DUE TO	(OR AS A CONS	EOUENCE OF	D:									- i	
resulting in death) LAST		1												j	
PART II Other elections	t condition													1	
PART II. Other significan							cause g	iven in i	Part i.	24a. WAS	S AN AUTO	OPSY		WERE AUTO	PSY FINDING
10/92 Non s	mall o	cell bror	ichogen	ic ca	rcino	oma					s 2 X		1	COMPLETIO OF DEATH?	N OF CAUSE
														1 YES	2 NO
									_				1		_
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL					28. PL	ACE OF DE	EATN (Che	ck only on	a)			1		
1 YES 2 NO	- 1	HOSPITAL:	ER/Outpatient	3 DOA	OTHER	-	5 X Res								

28s. DATE OF INJURY (Month, Day, Year)

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as atlated. 2 MEDICAL EXAMINER: On the basis of sxi on and/or investigation, in my opinion, death occured at the time, date and place, end dus to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) ▶ July 17, 1995 C10986 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) Charles P. Duvall, M.D., 3301 New Mexico Ave., NW, Washington, D.C. 20016 31. DATE FILED (Month, Day, Year)

JUL 19 1995 131 HEGISTHAN'S SIGNATURE Fallin Dawolson Randall

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28c. INJURY AT WORK?

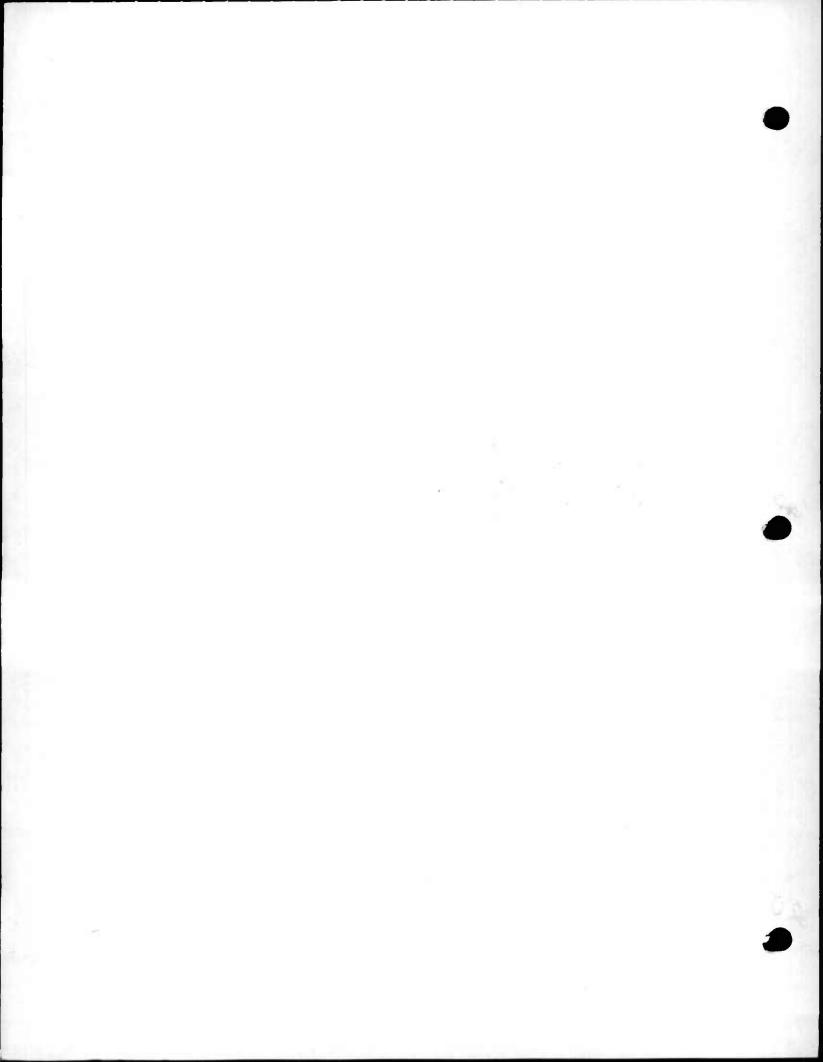
1 YES 2 NO

28b. TIME OF

28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify)

e 5 Reeldence 8 - Other (Specify)





RELEASED BY M.E.O. DR. MAYLE

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JAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	E
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ING PHYSICIAN	fer this certificate has been signed by the attending physician and completely fille

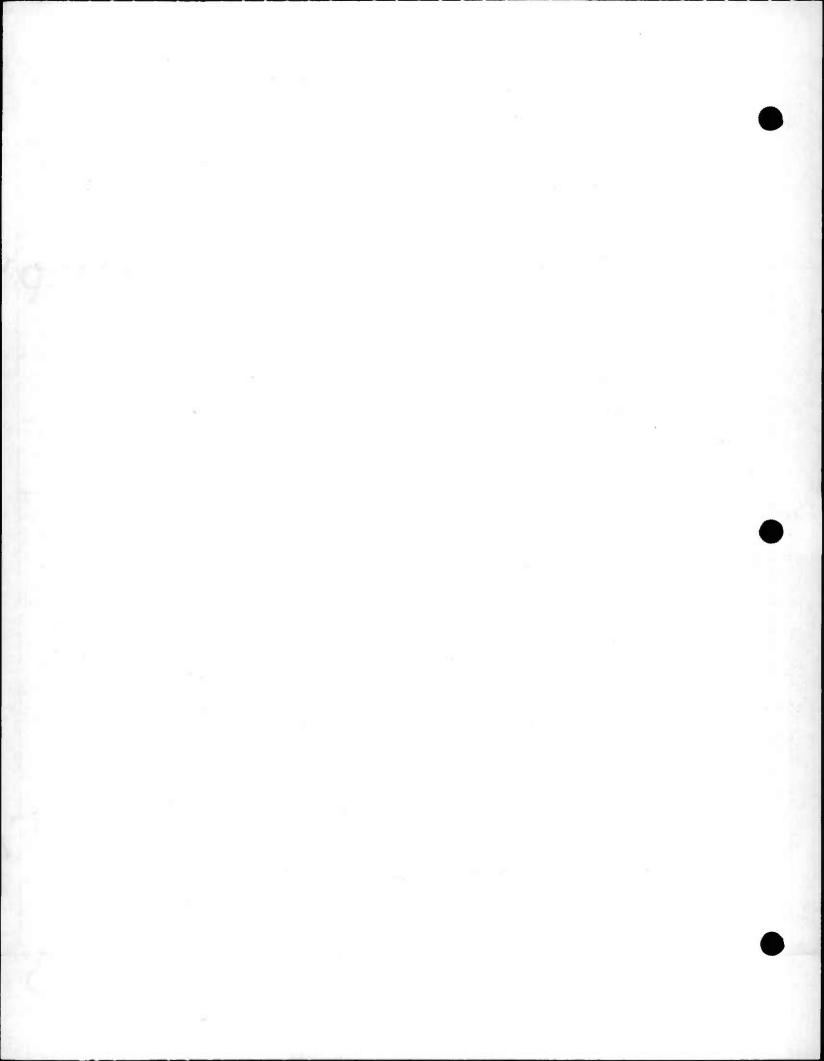
ise as the burial-transit permit. Pages 1, 2, 3 should attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAN	D / DEPARTMENT	OF HEALTH AND	MENTAL HYGIEN
	CERTIFICATE	OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	EALTH AND	MENTAL HYGIEN						
	1. DECEDENT'S NAME (First, Middle, Leat) EDITH	OSGOOD	DUV			2. DATE OF DEATH MONTH DULY 11,	-	3. TIME OF OEATN 5:15 P				
	4. SOCIAL SECURITY NUMBER 218 56 8287	1 🗆 M 2 👽 F	n yrs. last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) SEPT. 9, 1	a pipy	HPLACE (State or Foreign try) INOIS				
TOR	90. FACILITY NAME (If not institution, give s 5611 JORDAN ROAD RESIDENCE OF DECEMENT			96. CITY, TOWN C	ESDA	DEATN	9c. COUNTY OF I					
DIRECTOR	10s. STATE 10b. COUNTY	ONTGOMERY		r, town or locat	TION			10d. INSIDE CITY LIMITS? 1. X YES 2 NO				
FUNERAL	10a. STREET AND NUMBER 5611 JORDAN ROAD)			ZIP CODE	U.S.A	WNAT COUNTRY?					
₽	11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	It yee, sp	ENDENT OF HISPA ecify Cuben, Mexic 2 NO Speci	NIC ORIGIN? (Specify Yean, Puerto Ricen, etc.)	s or No— 14. RAC Blac Spec	E — American Indian, k, White, atc. WHITE				
COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of vi life. Do NOT us	C-179 111	DN st of working		SINESS/INDUSTRY					
	+4 HOMEMAKER OWN HOME 17. FATNER'S NAME (First, Middle, Lest) LUTHER P. OSGOOD SUZANNA TATE											
TO BE	m, Stete, Zip Code)	9										
	RICHARD DUVALL 20s. METNOD OF DISPOSITION 11 Burlet 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF JUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLERS SONS											
	· Jean m	Peters		5130	WISCONS	IN AVE. N.	W. WASHI					
	23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feliure. List only one ceuse on aech lina. IMMEDIATE CAUSE (Finel disease or condition resulting in desth) Congestive heart failure Due to (or as a consequence of):											
ATION	Sequentisily list conditions, if any, lasding to immediate cause. Enter UNDERLYING											
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE OF):								
MEDICAL C	PART II. Other significent condition Hypertension;	osteoporosis	It not resulting i	n the underlying	ceuse given in	Pert i. 24s. WAS AN PERFOR	RMED?	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
PHYSICIAN: MI	DID TOBACCO USE CONTR		F DEATH YE		UNCERTAI	N 🗆		1 TYES 2 NO				
YSIC	EXAMINER?	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Output	itlent 3 DOA	OTHER: 4 - Nursing Home	5X Residence	6 Other (Specify)						
ВУ РН	27. MANNER OF DEATN 1 X Metural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	M 1 V	RK7 ES 2 NO	28d. DESCRIBE NOW I	-10-11-11-11					
ETED	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE OF INJURY building, etc. (Speci	(V)		<u> </u>	28t. LOCATION (Street (City or Town, State)		Route Number,				
(Check only one) 2 MEDICAL EXAMINER: On the besie of exemination end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the ceuse(e) end manner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date and piece, end due to the ceuse(e) end menner each occurred at the time, date end piece, end due to the ceuse(e) end menner each occurred at the time, date end piece, end due to the ceuse(e) end end end end end end end end end end												
TO BE	28s. SIGNATURE AND TITLE OF CERTIFIER DAY NAME AND ADDRESS OF PERSON WHO	Council	N (ITEM 27) (Type,	Print)	29c. LICENSE NU 2773	MBER	≥ July	13, 1995				
	THOMAS CONNALLY, M. 31. DATE FILED (Month, Day, Vear)	32. REGISTRAR'S SIGNA	TURE	AVENUE	WASHING	TON DC 200	16					
	JUL 18 1995 Julia Davidson Randall											



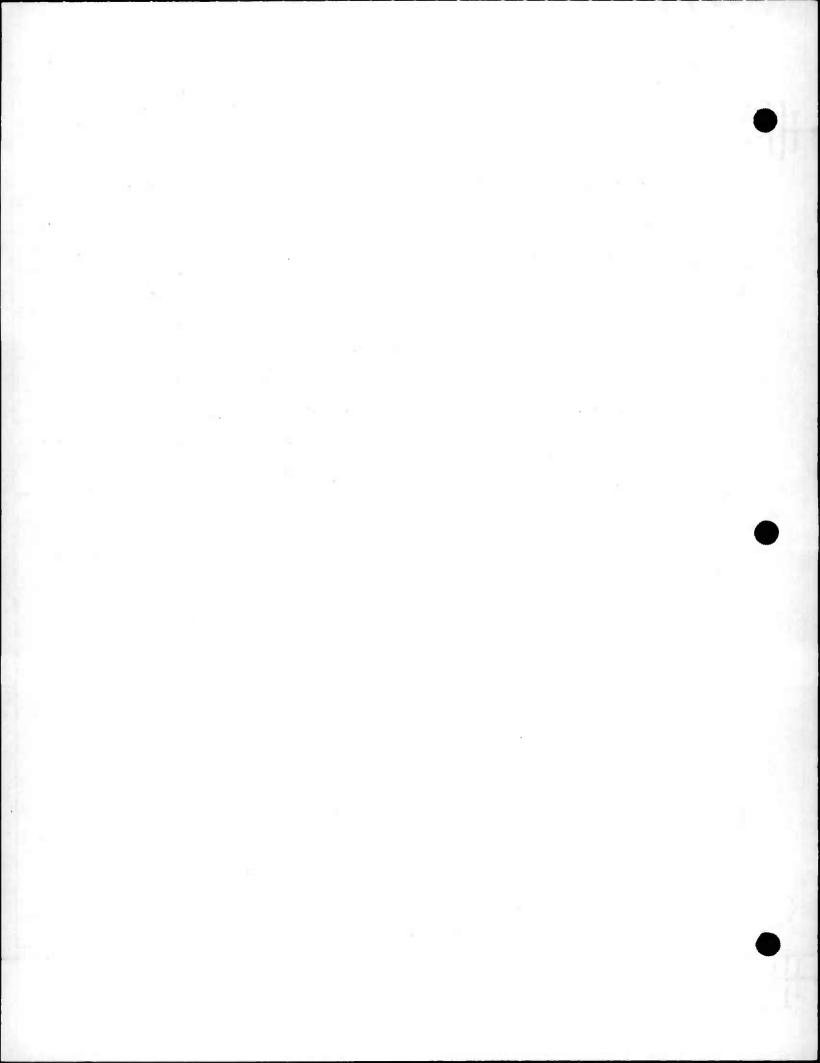


DIVISION OF VITAL RECORDS, P.O. BOX 68760

1	-	FOR STATE REGISTR	AR
	1. D	ECEOENT'S	NAI

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

						10/11		DLA			IEG. NO.			
	1. DECEOENT'S NAME (First								- 1	2. DATE OF MONTH	D/		YEAR	3. TIME OF OEATN
	John 4. SOCIAL SECURITY NUMBER	Vito		<u>AUGELI</u>						July	13,	1995		4:00P M
			5. SEX		s, last birthday)	MONTHS	DAYS	HOURS	MIN.	7. OATE OF I	BIRTN ly, Ybar)		Count	NPLACE (State or Foreign
	209-14-906		1 💢 M 2 🗆 F	71	YRS.					June	16,	1924	Peni	nsylvania
~	9a. FACILITY NAME (If not in					9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DE						DEATN		
2	Doctors Co	ommunit	ty Hospit	ta1			L	anhai	m			Pri	nce (George's
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY	,		100 CI	TOWN	OB LOCA	rion						· · ·
Ä	Maryland	Princ	ce George	1 0	100.01	*						10d. tNSIDE CITY LIMITS?		
	10e. STREET AND NUMBER	11111	Le George	- 5		Lanham						1 TYES 2XX NO		
R	6015 Harlar	d Stro	20+								10g. CI1	10g. CITIZEN OF WHAT COUNTRY?		
FUNERAL	11. MARITAL STATUS	Id Dele	12. WAS DECEDEN	T EVER IN II S	20706 IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify								USA	
	1 Never Married 2	Married	FORCES? 1	X YES 2	□ NO	13.	If yes, sp	ecity Cuba	in, Maxican,	, Puarlo Ricar	pecify Yes 1, atc.)	Yes or No— 14. RACE — American Indian, Black, Whita, atc.		
ВУ	3 📉 Widowed 4 🗌 Divo	rced	W.W.		5		1 _ YES	2X NO	Specify:				Spec	White
8	15. DEC	EOENT'S EDUC highest grade	CATION	_	DECEDENT'S	USUAL C	CCUPATIO	ON		16b. KIN	D OF BUS	INESS/INC	DUSTRY	WILLE
<u> </u>	Elementary/Secondary (0		College (1-4 or 5 a	,	(Give kind of life. Do NOT u	work done se retired.)	during mo	ast of working	ng					
P P	12th			Mech	anic					Bt	ıses			
COMPLETED	17. FATHER'S NAME (First, M.	iddle, Last)						18. MOTI	HER'S NAM	IE (First, Middle			_	
BE (John Matthew Draugelis Victoria Gertrude Toucheloski												neloski	
9	19a. INFORMANT'S NAME (7)			19b, MAILING	ADDRES	S (Street a	nd Number	or Rural Ro	oute Number, C	City or Town	. State, Zip	Code)		
-	John M. Dra				919 R	edmo	re D	rive	Sev	ern, l	Mary	land	2114	44
	20a. METHOD OF DISPOSITI	ON n 3 🗆 Remo	ovel from State	20b. PLA	ACE AND DATE	OF DISPO	SITION (Na	ame of		DATE	20c. LO	CATION —	City or To	own, Stata
	4 Donation ,5 Other (Specify) Metropolitan Crematory 7-15-95 Alexandria, Virginia												, Virginia	
	21. SIGNATURE OF FUNERAL	SERVICECO	ENSEE			22.	NAME AL	NO ADDRE	SS OF FACI	LUTY	norol	Нол	10	
	George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745													
	23. PART I. Enter the diseases, or complications that caused the death, Do not enter the mode of dying such as cardiac or respiratory except													
anock, or haart tallure. List only one cause on each line.												Interval Batween Onset and Death		
	MMEDIATE CAUSE (Final disease or condition reauting in death) a. Septic Skock, Onset and Death											2 day		
ı	DUE/TO (OR AS A CONSEQUENCE OF):													
z	No A - A											Teors		
월	Sequantially list conditi if any, lesding to immed	diata	DUE TO	(OR AS A CO	SEQUENCE O	F):	0			-	H			
2	cause. Entar UNDERLYI CAUSE (Disesse or inju			JP.	00	181	cli	100	ye	pa	14		3	vyer
#	that initiated events resulting in death) LAS		ONE TO	(OR AS A CO	NSEQUENCE O	F):		,		٧	1			
CERTIFICATION	and additional and a second		l. 120	Tree	ATTE	en								2-3700
	PART II. Other significa	nt conditions	contributing to	death but n	ot reaulting	in tha ur	ndarlying	Cause C	jivan in P	art I. 24a	. WAS AN	AUTOPSY	24b	. WERE AUTOPSY FINDINGS
MEDICAL							22, 22	7.50,170.	301		PERFOR	MED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
										_ '	YES 2	Mo		OF DEATH?
_	DID TOBACCO US	SE CONTR	RIBUTE TO CA	USE OF D	FATH Y	SX	NO F	LINC	ERTAIN	l				1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO				PLACE OF DEA	_/ -		0110	EKIAHA					
Sic	1 TYES 2 THE		HOSPITAL:	ER/Outpetien	vi 3 □ DOA	OTHE		- 5 □ Pa	eldense ft	Other (Spi				
₹I	27. MANNER OF OEATH		28a. OATE OF	INJURY	28b. TIM	E OF	28c. INJ	URY AT		28d. DESCRIE		JURY OCC	CURED	
BY F	-	Pending nvestigation	(Month, De	ny, vo <i>mr)</i>	IN.	M		RK? /ES 2 [100					
	2 Cutate	Could not be	28a. PLACE OF	F INJURY — A	t home, farm,	streat, fact	ory, office		:	28f. LOCATIO	N (Street a	nd Number	or Rural A	Route Number,
田		Setermined	bullang,	atc. (Specify)						City or Tox	wn, State)			
1 1	29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowledge	. death occurr	ed at the t	ime date	and place	and due to	the course(s)	and man			
COMPLETED) and manner as stated.
- 11	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Minim), Day, Year)													
H	7	= DU	1 R10	8.	+LOR	68		D	142	22	-	DATI	/12	19 1
유	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF OEATH	(ITEM 27) (Type	Print)			, a			/	117/	14
	Eduardo B F	Mores,	MARV	is i	are	- 1	Pil	rei	de	22 De	N		20	737
	JUL 17		Jahr da	R'S SIGNATUR	arlate									



1995

3. TIME OF DEATH

3:50A

10d. INSIDE CITY LIMITS? 1 X YES 2 NO

> Approximate interval Batwean **Oneat and Death**

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

GREENBELT HI

8. BIRTNPLACE (State or Foreign

REG. NO.

2. DATE OF DEATH MONTH DAY

ILILY

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

JEAN

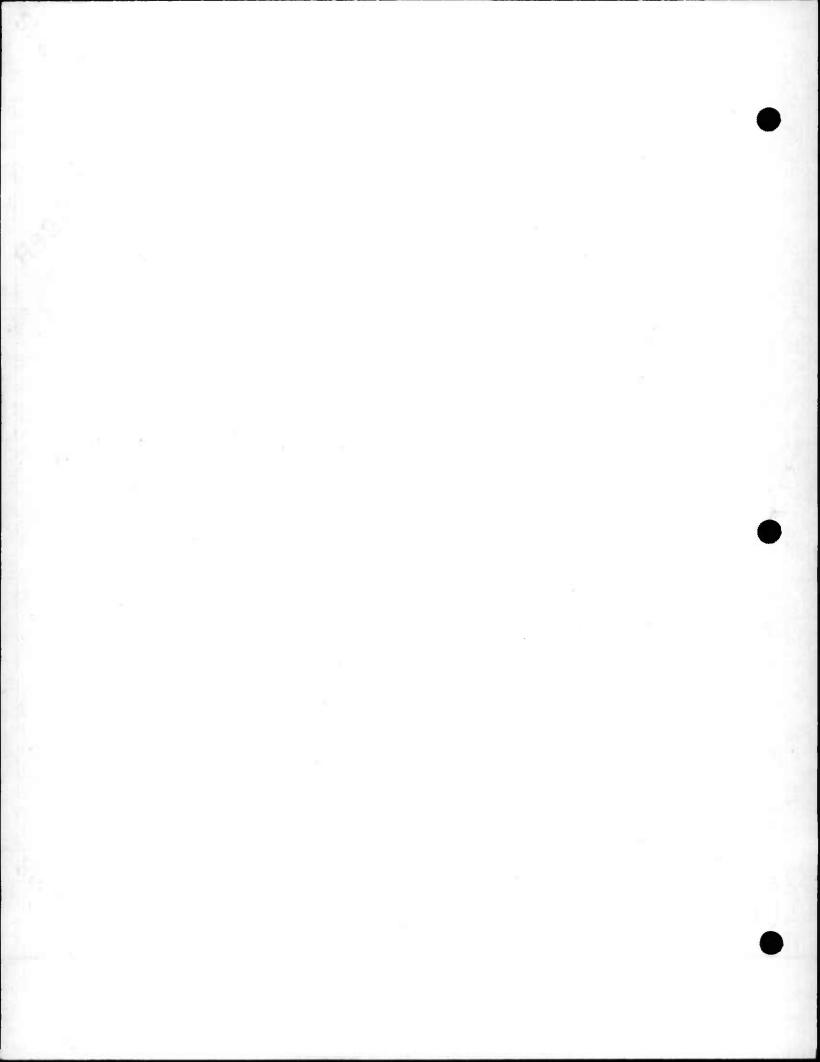
5. SEX

		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le		IF UNDER 1 YE	AR IF UN	DER 24 HRS.	7. DATE OF	BIRTN	/	8. BIRTNPL	ACE (State or Fore
_		070-28-0457	1 🗆 M 2 😾 F	61	YRS.	MONTHS DA	YS HOUR	S MIN.	June	30,	1934	New	York
3 should		9a. FACILITY NAME (If not institution, give	street and number)			9b. CITY, TO	WN OR LOCA	ATION OF OE			_	TY OF DEA	
2,38	8	Prince Georges	Hospita	al		Cheve	erly				P.G		
	<u>ايا</u>	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	~		I in a second								
permit. Pages 1,	DIRECTO	MD P.G				itol		rh+c					Od. INSIDE CITY LIMITS?
a Hit		10a. STREET AND NUMBER			Loap	1001	101. ZIP CO				10a. CITI		AT COUNTRY?
n. ansit p	FUNERAL	411 Zelma Ave						743			_		tates
020 physician. burial-transit	15	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDEN	YES 2		If yes	s, specify Cu	ıban, Maxicar	IC ORIGIN? (S	Specify Yes n, etc.)	or No-	14. RACE Black, \	- American Indian. White, atc.
21215-0020 If or attending physic for use as the burial	B	3 Widowed 4 Divorced	IF YES, GIVE V	MAR OR DATES		1 1 -	YES 2 ZEN	O Specify				Specify:	
or atter	TED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(0	ECEDENT'S U Sive kind of wo b. Do NOT use	rk done during		rking	16b, KII	ND OF BUS	INESS/IND		
MARYLAND 212- retained by the hospital or att 5 should be detached for use	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5	+)	ousew								
AND the hospital detached for	S S	17. FATHER'S NAME (First, Middle, Last)					18. MC	OTHER'S NAI	ME (First, Midd	lle, Maiden S	Surname)		
MARYL retained by th 5 should be o	5 m	Emanuel J. Ho:	rne					_	. Rol				
MAR retained 5 should	TO B	19a. INFORMANT'S NAME (Type/Print)							loute Number,				
E ge be	9	Thomas Dunning	ton					Cap.	Hgt	_			
ORE 6 may ctor. pa	T T T T T T T T T T T T T T T T T T T	1 Buriel 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	ovat from Stata	20b. PLACE cemetery, cu	AND DATE OF	DISPOSITION	N (Name of	ators	DATE 7/10	20c. LOC	Chol	tonh	am, MD.
BALTIM after death. Page by the funeral dire noval.		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	- mary	Land	22. NAM	E AND ADDI	RESS OF FAC	HOTEL HO	odge	s ar	d Ed	wards
	E A	· Janice	Edwa	1100	/				Hill	_			
		23. PART I. Enter the diseases, or	complications tha	t ceused the de	eth. Do no								Approximate
		shock, or heart fellure. IMMEDIATE CAUSE (Final	List only one ceu	iae on aech line	e.			A			,		Interval Bate Onest and E
mati mati	evenit, inc	disease or condition resulting in death)	. Land	io In	hus	han	4	Acres	N				12 H
	. 1 - 1	DUE TO (OR AS A CONSEQUENCE OF)											241
X 6	TIFICATION	Sequentially flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evants reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.											210
BOX cate be e ohysician e prior to	CA												127 H
V. 5 5E	RTIF	that initiated evants resulting in death) LAST		(OH AS A CONSE	R AS A CONSEQUENCE OF):								
		DART II Other significant condition	d										+
ORD S that the ned by th fift and h	MEDICAL C	PART II. Other significant condition	e a l	clean but not i	resulting in	the undari	ying cause	e given in i	Part I. 24	PERFORM		A	ERE AUTOPSY FIND MILABLE PRIOR TO
		Fand de la	1000	100					11	YES 2	NO	Oi	OMPLETION OF CAU F DEATH?
		DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH YES	□ NO	M UN	ICERTAIN				1	YES 2 NO
TAL The law ate has a		25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		CE OF DEATN	(Check only							
(0 23 2		1 TYES 2 NO	1 Inpatient 2			OTHER:	Nome 5 🗆	Residence (B Other (Sp	pecify)			
O ₹ ₹ ₹		27. MANNER OF DEATN 1√ Natural 5 ☐ Pending	28a. DATE OF (Month, D		28b. TIME	YF	INJURY AT WORK?		28d. DEŞCRI	BE HOW IN	JURY OCC	URED	
ON Affer I death		2 Accident Investigation	28a. PLACE O	F INJURY — At ho	me, farm, etc.		YES 2	∐ No	28f. LOCATIO	M /Ctmot on	of Mumbas	or Proof Born	to Months
TISH TTEN TOR: after	. Ш	8 Could not be 4 Nomicide datarmined	building,	atc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	eet, lactory, t	Jinca		City or To	wn, State)	o Number	or Hurai Hou	e Number,
O S S S S S S S S S S S S S S S S S S S	P.E.	29a. CERTIFIER (Check only	CIAN: To the best of	my knowledga, de	eth occurred	at the time,	data and pla	ca, and due t	to the cause(s	and mann	or as atate	ıd.	
TO THE HOSPITAL TO THE FUNERAL Be filed within 72 h	COMPLET		R: On the basis of a										nd menner as state
THE HO THE FU filed wit	BE	296. SIGNATURE AND TITLE OF CERTIFIE	R/ /				29c. LI	CENSE NUM	BER	T	29d. DATE	SIGNED (M	onth, Day, Year)
D D 3	2	30. NAME AND ADDRESS OF PERSON WIN	O COMPLETED CALL	E OF OFATH #==	M 27) /5 2		1	157	8/			1/15	120
11		JACHINDER S.SI	Att 7	7525	SHOE	TNW.	AY	CBN	TOR	DK.	Gi	PET	VREZT
		JUL 18 1995	32 AEGISTRA	B'S SIGNATURE	relath								
			11.4										

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

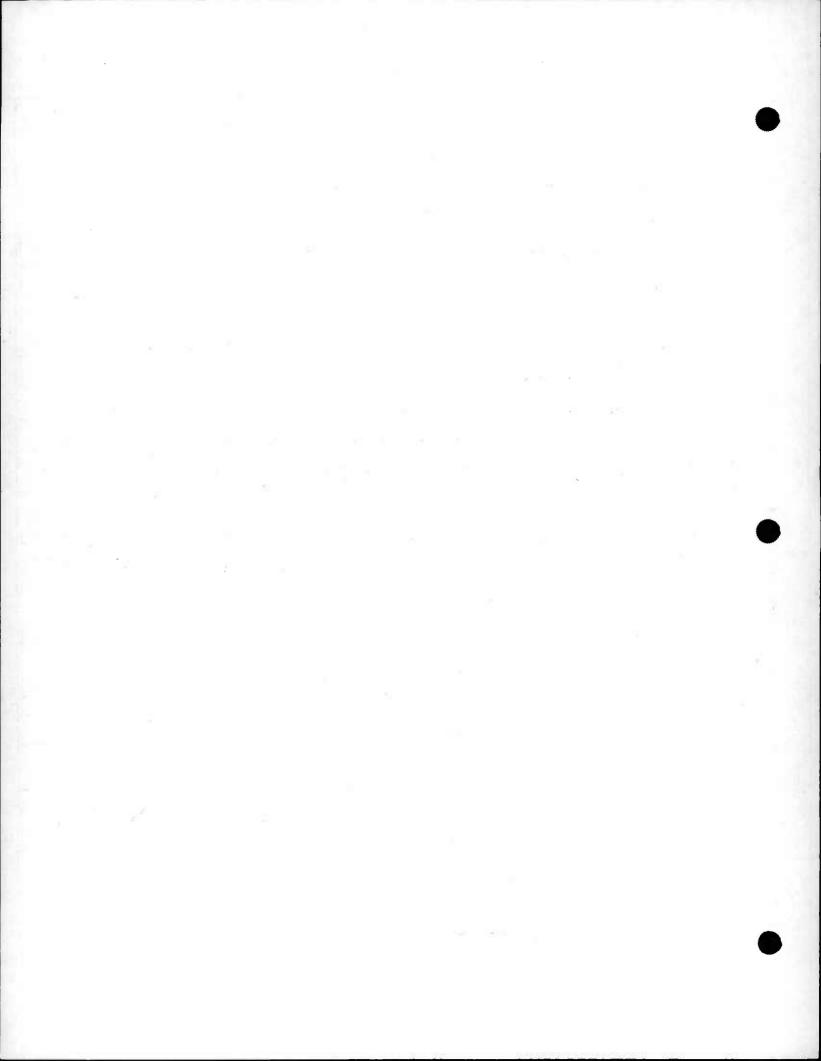
DUNNINGTON

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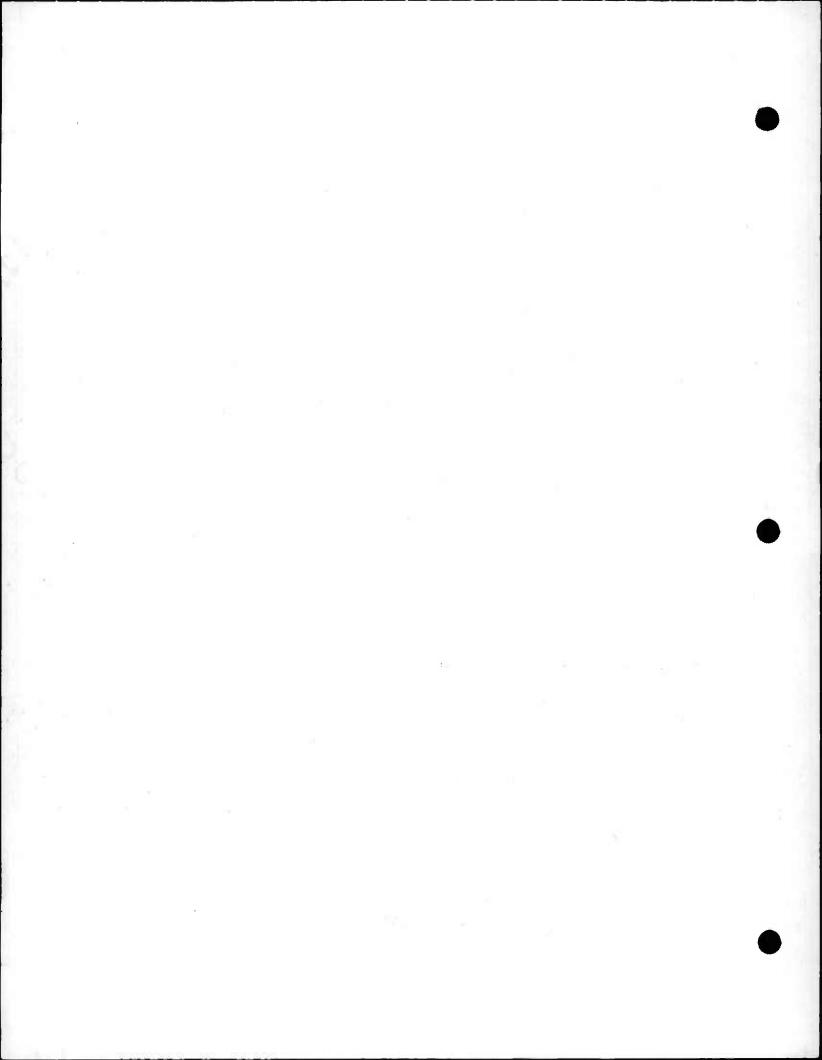


1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First	Adjulation (and)										EG. NO.		-				
		John	H.	U	ennis	T-						2. DATE OF D	DA		YEAR	3. TIME OF DEATH			
		4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In	_		W I MIDEO	4 1004.00			July		1995		24-57 M			
		579-09-094		1 🕅 M 2 🗆 F			YRS.	MONTHS	DAYS	HOURS	MIN,	7. DATE OF BI (Month, Day	Year)		Counti				
pluods		9a. FACILITY NAME (If not in	-			75	rns.	AL CITY	TOWN (OR LOCATI	011 05 05	July 2	22,			nessee			
co.	8	12306 Star1							vie	OH LOCATI	ON OF DE	EATH			NTY OF D	George's			
1, 2,	DIRECTOR	RESIDENCE OF DEC	EDENT											111	ice (George S			
Pages	뿔	10a. STATE	10b. COUNTY				10c. CITY	, TOWN C	R LOCAT	TION						10d. INSIDE CITY LIMITS?			
permit.	- 1	Maryland 100, STREET AND NUMBER	Princ	e George	's		Bow:	ie								1 X YES 2 NO			
	FUNERAL	12306 Star	licht	Lano					- 1	0715	E			_	S.A.				
-0020 ing physician. the burial-transit	=	11. MARITAL STATUS	Tigne	12. WAS DECEDEN	T EVED IN I	I C ADM	ED.	Lan											
020 physi burial		1 Never Married 2	100	FORCES? 1	YES	2 X NO		1	1 yes, sp	ecity Cuba	n, Mexice	NC ORIGIN? (Sp n, Puerto Ricen,	etc.)	or No-	Black	— American Indian, , White, etc.			
	В	3 Widowed 4 Divo	roed		- III OII DAII				☐ YES	2 X NO	Specify	<i>γ</i> .		_	Speci	White			
	9	15. DEC (Specify only	EDENT'S EDUC highest grade	CATION completed)		I6a. DECE	EDENT'S	USUAL OC	CUPATIO	ON ast of working	102	16b. KINC	OF BUS	INESS/IND	USTRY				
0 -	LET	Elementary/Secondary (0	-12)	College (1-4 or 5		life. D	o NOT use	e retired.)			•								
AND 2 the hospital detached to once.	COMPL	12				Supe	rvis	sor						y Equ	ıipm	ent			
A the be det	1	John H. Det		Cr.										Maiden Surname)					
	H			51.		405	****				-	ry Tay							
MAR retained 5 should notified	임	III 198 INFORMANT'S NAME ("Una/Print)																	
m g g a		20a. METHOD OF DISPOSIT	ON		20b. P			FDISPOS			ane,			TYTEI					
MORE Page 6 may If director, page Iner must b		1 N Buriel 2 Cremation 4 Donation 5 Other	n 3 🗆 Remo	oval from State	cemete	ery, creme	tory or off	her plece)	nete	rv	07/								
Page all direct		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY																	
ALTIN death. Pag tuneral di f. examiner	4	> (lear	les 7	C. 136	47	/													
S = S		23. PART I. Enter the di	seases, or o	omolications the	t caused t	he deet	h Do n	4 /	39 .	Balt:	imor	e Ave.,	Hyat	ttsvi	lle,	MD 20781			
nours afte or remov		anock, or ne	eart tellure. I	List only one cau	se on esc	h line.	II. DD 11	Dt anter	tha mo	de bi dyi	rig, auci	i aa carulec (or reapir	atory err	eat,	Approximata Interval Bstween			
y filled ution, o		IMMEDIATE CAUSE (Finel disease or condition resulting in death)																	
with with pletel crem.	H	resulting in death) DUE_FO (OR AS A CONSEQUENCE OF): (PROVIDED TO CONSEQUENCE OF):																	
executed and corr o burial, natic en	2	Sequentially list conditions, puerty con as a consequence por																	
X	유	Sequentially list conditions, If any, leading to immediate																	
	3	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury) Character Charac																	
C. E. Sertifical Sertifical Ing Phy Molene I other	ERTIFICATION	that initiated events resulting in death) LAST																	
death death e attend	CER																		
三 音音音		PART II. Other significa							derlying	ceuse g	iven in	Part I. 24s.	WAS AN		24b.	WERE AUTOPSY FINDINGS			
T # 5 5 >	MEDICAL	Correal spr	ndyle	sing cell	30	are	mel	egi					PERFORI	NED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
quires that signed Health and Owns and	Ä	Renal 1	taile	ine 1	The	end	17	-au	lea	-(_ ' '		6		OF DEATH? 1 YES 2 NO			
- 0 -	ä	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF	DEATH	H YE	1 🗆 2	10)	UNC	ERTAIN	10							
E 88 =	PHYSICIAN:	28. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26.	PLACE		H (Check o		7									
CIAN: ertification of the St	YSI	1 TYES 2 NO		1 ☐ Inpetient 2 E	ER/Outputs	lent 3 🗆	DOA	4 C Nurs	ing Hom	· 1/4	gjdence	6 🗆 Other (Spe	ofy)						
	표	27. MANNER OF DEATH	Pending	28s. DATE OF (Month, D		,	SMIT 1885			RK?		28d. DESCRIBE	E-MOW IN	JURY OCC	URED				
DING PHYS After this death with	A	2 Accident	meetigation	26. N 400 C	er one telemin			-		ES 2	NO								
TTEND TTOR: 4 after d	ETED		Could not be setermined	26e. PLACE O building,	etc. (Specify)	At home	, farm, st	Iraet, facto	ry, office			28f. LOCATION	(Street or n. State)	nd Number	or Rural A	oute Number			
OR ATTEN DIRECTOR: hours after Item 28 Is	<u>ا</u> با	29a. CERTIFIER			_	_			-				_	_					
목정원들	COMPL	(Check only		CIAN: To the best of															
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	8	45	_	1: On the basis of a	tamination a	ind/or inv	eatigation	i, in my o	olnion, de	eath occur	ed at the	time, data and p	olace, and	due to the	Cause(s)	and menner as stated.			
F S S S S S S S S S S S S S S S S S S S	H	296 SIGNATURE AND TITLE	OF CENTIFIER	//.						29c. LICE	NSE NUM	BER		29d, DATE	SIGNED	(Month, Day, Year)			
2 2 2 ₹	2	30. NAME AND ADDRESS OF	DEBOUNT THE	COMPLETED ASS	E OF DELE	117	77) (*:	Out-of		10/	56	66		7 5	1/5	151			
(-)		Dennil R. Schumer 14201 CAURER PARK DR #102 CAURER MD 2020)																	
0/		31. DATE FILED (Month, Day,			R'S SIGNATI	URE	1016	66	0-110	IL V	1 7	=/0L	CM	UKG	- M	0 2000			
		JUL 19		32 REGISTRA	welser	Red	14)			
			1444	14			-												



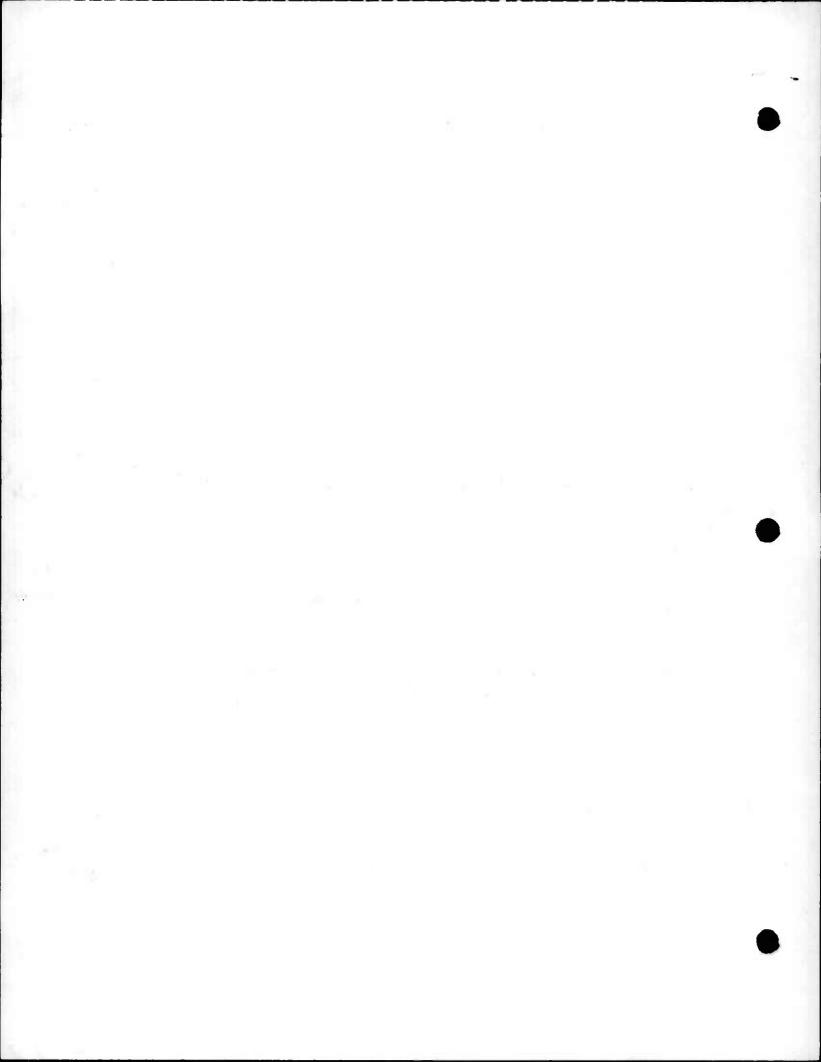
		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF I	HEALTH AND		GIENE						
		1. DECEDENT'S NAME (First, Middle, Lest)					2. DATE OF DI	EATH	3. TIME OF DEATH					
		JOHN P. 4. SOCIAL SECURITY NUMBER		OBSON		T	JULY	11 199	95 10:07 A.M					
				(In yrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BI (Month, Day,	Year)	BIRTHPLACE (State or Foreign Country)					
3 should	. 8	9e. FACILITY NAME (If not institution, give stree			96. CITY, TOWN	OR LOCATION OF D	May 9.	1910 N	lew York					
1, 2, 3 s	DIRECTOR	St. Mary's Hospit				nardtown			Mary's					
Pages	IRE	10e. STATE 10b. COUNTY	2!-		Y, TOWN OR LOCA	TION			10d. INSIDE CITY LIMITS?					
DZO physician. burlal-transit permit. Pages 1, 2,		Maryland Prince	George's	T I	Bowie	f. ZIP CODE		40 017170	MM YES 2 □ NO					
nsit pe	FUNERAL	16200 Angel Falls	Lana		10	20716			ed States					
physician. burial-trar	NO.	11. MARITAL STATUS 1	2. WAS DECEDENT EVER IN FORCES? YES	N U.S. ARMED	13. WAS DEC	CENDENT OF HISPA	NIC ORIGIN? (Spe	cify Yee or No- 1	I. RACE — American Indian.					
	BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA		1 Tyes, sp	cecify Cuban, Mexic 2 NO Speci	can, Puerto Rican, etc.) Black, White, etc. Specify: White							
as se		15. DECEDENT'S EDUCAT		18e. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND	OF BUSINESS/INDUS	PTDV					
al or a for us	E	(Specify only highest grade con Elementary/Secondary (0-12)	mpleted) College (1-4 or 5+)	(Give kind of v life. Do NOT us	vork done during me	ost of working	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	or boomeounit.						
the hospital or att detached for use once.	COMPLETED	5	5+	Physic	ian				nent					
by the hor be detach		17. FATHER'S NAME (First, Middle, Last) Patrick Joseph Dob	oson			Alice	U.S. Government NAME (First, Middle, Maiden Surname) Connel 1							
retained by	O BE	19e. INFORMANT'S NAME (Type/Print)	75011	19b. MAJLING	ADDRESS (Street)									
be reta ge 5 sh e notii	유	Tollow Tollow Tollow Tally Land												
tuneral director, page xaminer must be		20a, METHOD OF DISPOSITION 1 🖰 Burlel 2 🗆 Cremation 3 🗔 Remova	al from State Cent	PLACE AND DATE Of	OF DISPOSITION (Na	ame of	DATE	20c. LOCATION — CH	y or Town, State					
Page 6		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN	A1	rlington	Nationa	1 Cemete	ry 7/20	/95 Arlin	ngton Virginia					
death. Pag tuneral di I. examiner		Quit & &		\mathcal{D}_{a}	Rober	t E. Eva	ins Fune	ral Home	, P.A.					
after de by the fundamental.	Щ	novey C. C	vans.	Mr.	16000	Annapol	is Rd.	Bowie Md.	. 20715					
24 hours after of filled in by the ion, or removal.		23. PART i. Enter the diseases, Dr CDn shock, Dr haart fallure. Lis	nplications that calused it Dnly ona cause on a	d tha desth. Do n ach iina.	Dt sntar ths mo	oda of dying, suc	ch as cardisc p	r respiratory arres	intarvai Between					
y filled		IMMEDIATE CAUSE (Final disease or condition PRU hab Le MYOCARDIAL INFARCTION SEC												
ted within 24 completely fille ial, cremation, event, the		disease or condition resulting in death) a. PRO hab Le MYOCARDIAL INFARCTION OUE TO (OR AS A CONSEQUENCE OF):												
	×	Sequentially list conditions,												
or in pe	CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events DUE TO (OR AS A CONSEQUENCE OF):												
1 de 1 de 1 de 1	FIC													
# g g P	RTIF	reaulting in death) LAST												
0 0 0 5	L CE	PART II. Other significant conditions of	portributing to death b	ut not resulting i	- the underlyin	- cours alves in	Comp 1 Days							
- 56 -	CAL	ASEVD	CVV		n ma underlyin	g cause givan in		WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE					
requires the seen signed of Health	MEDI	/	,				— l¹□	YES 2 THO	OF DEATH?					
	N.	DID TOBACCO USE CONTRIB	BUTE TO CAUSE O	F DEATH YE	S NO [UNCERTAI	N D		1 - YES 2 - 40					
The late has ate De	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT	H (Check only one)									
SICIAN: The certificate h the State d, or item	YSI	1 YES 2 NO	☐ Inpatient 2 ☐ ER/Outpo	atient 3 DOA	OTHER: 4 Nursing Hom	e 5 🗆 Residence	6 - Other (Spec	eify)						
NG PHYSII fter this ce eath with t		27. MANNER OF DEATH 1 Naturel 5 Pending	(Month, Day, Year)	28b. TIME	URY WO	PRK?	28d. DESCRIBE	HOW INJURY OCCU	RED					
After death	ВУ	2 Accident Investigation	28e. PLACE OF INJURY	At home, ferm, s		YES 2 NO	201 LOCATION	(Street end Number or	Burni Bruta Musakan					
TOR: after	TED	3 Suicide 6 Could not be determined	building, atc. (Speci	elfy)	,,,	•	City or Town	n, State)	nural ribute Number,					
BIRI PIN	COMPLET	29e. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the beat of my knowle	ledge, death occurre	d at the time, date	end place, end due	to the cause(s)	and manner as stated						
HOSPITAL FUNERAL Within 72 I	OM								euse(s) end manner as stated,					
TO THE HOSPITA TO THE FUNERA De filed within 7	iii II	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU			IGNED (Month, Day, Year)					
F 5 5 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	10 B	mym	Lumy			017:	285	1 7	-12-95					
)	- 1	30. NAME AND ADDRESS OF PERSON WHO dompleted cause of Death (ITEM 27) (Type, Print) Ui 11 jam Royad M. D. 17. To ffor your Street Lorentz Lor												
IVA		William Boyd M.D. 17 Jefferson Street Leonardtown Maryland 20650 31. DATE FILED (Month, Day, Ybar) 32. RESISTRARY FIGURITURE												
1,4		JUL 19 1995	Jahr alle	Wat Added										



31. DATE FILED (Month, Day, Year)

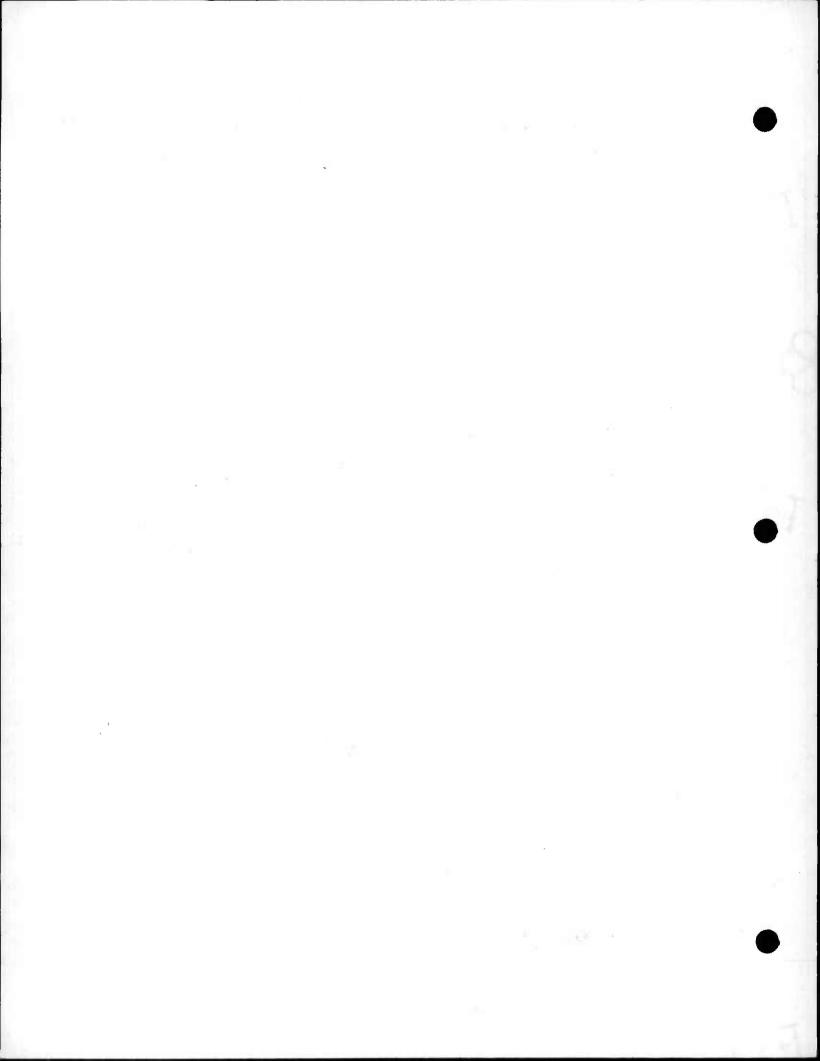
32. REGISTRAR'S SIGNATURE

		1 - FOR STATE REGISTRAR	STATE OF MARYL		DEPARTMENT OF			L HYGIEI						
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATI	OF DEATN	DAY	YEAR	TIME OF DEATH			
		CHARLOTTE M 4. SOCIAL SECURITY NUMBER	AE EYSTER	(In yrs. last	birthday) IF UNDER 1 Y	EAR IF UNDER 24 I	JU	LY Z		995	12:21 at CE (State or Foreign			
pla	1	214-42-1015 90. FACILITY NAME (If not institution, give	1 □ M 2 □ F {	81	YRS. MONTHS D	NYS HOURS N	III. (Mon	th, Day, Year) N. 8,]	914	PENNS	SYLVANIA			
2, 3 should	CTOR	HOMEWOOD RETIRE				WN OR LOCATION	OF DEATH			Y OF DEATH DERICH				
es 1.	1 111 1	10s. STATE 10b. COUNT	TY	-1	10c. CITY, TOWN OR L	OCATION				10,	I. INSIDE CITY			
permit. Pages	L DIRI	MARYLAND FRED	DERICK		FREDERIC	K				1 2	LIMITS?			
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3 6 6 Z		ERNEST 198. INFORMANT'S NAME (Type/Print)	SHRIVE			HARR	IET		WAYBI	RIGHT				
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		NANCY GRAHAM 200. METHOD OF DISPOSITION			334 PEAR				MARYLA		21701			
TOR ector, p		1 X Burisi 2 Cremation 3 Rar 4 Donation 5 Other (Specify)	noval from State Cen	netery, crem	ND DATE OF DISPOSITION (NO OTHER PROPERTY OF Other place)		DA	- 2.0	OCATION — CI					
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BALTIMORE, ter death. Page 6 may be the funeral director, page wal.		· APH	· Cherches						ST MAI					
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n by remo		23. PART I. Enter the diseases, pr shock, or heert fallure.	complications that cause Liet only one ceuse on e	d tha dea	th. Do not antar the	moda of dying,	, euch as car	diec or rasp	piratory arree	A,	Approximate Interval Between			
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withir pletet crema		resulting in death)			DISEA JENCE DF):	TE					5 YRS			
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	CERTIFICATION	resulting in deeth) LAST	d,			E 04):								
Me Me	CAL	PART II. Other significent condition	ns contributing to death b	out not re	sulting in the under	lying ceuse give	n in Part i.	24a. WAS AF	AUTOPSY	24b. WEF	RE AUTOPSY FINDINGS			
T a o a >	2	ATRIAL FIBA	CICLATION /	RHE	ELMATOL	> ARTH	RITIS	100-500	RMED?	CON	ILABLE PRIOR TO WPLETION OF CAUSE			
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L RECOl law requires that as been signed bept, of Health a	2	DID TOBACCO USE CONT		F DEAT	H YES INC	UNCER	TAIN 🛛			"	1123 2 110			
AL. The law e has b te Dept m 23	I K	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			OF DEATN (Check only									
F VIT SICIAN: Th certificate to the State I, or Iten	Sic	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp	patient 3	OTHER: □ DOA 4 □ Nursing	Home 5 - Reside	encs 8 🗆 Oth	er (Specify)						
O \frac{1}{2} \frac{1}{2} \frac{1}{2} \frac{1}{2}	PHYSICIAN:	27. MANNER OF DEATN 1 Natural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)		INJURY	NJURY AT WORK?	11110000	SCRIBE NOW	INJURY OCCU	RED				
DIVISION OR ATTENDING P OINECTOR: After th hours after death v item 28 is mark	ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At hom			28f. LO	CATION (Street or Town, State	and Number or	Rural Route	Number,			
VIS ATTE RECTOR				-										
DIV AL OR A L DIREC 2 hours 1 item	릴		SICIAN: To the best of my know											
HOSPITAL FUNERAL Within 72 h	COMPLET	one) 2 MEDICAL EXAMIN	ER: On the basis of exemination	n and/or Im	vestigation, in my opini	on, death occured a	st the time, date	and place, a	nd dus to the	:suse(s) and	i mannar as stated.			
TO THE HOSPITAL TO THE FUNERAL De filed within 72 P	ш	296. SIGNATURE AND TITLE OF CERTIFIE	_ /		100	29c. LICENSE			29d. DATE S	IGNED (Mor	nth, Day, Year)			
T C T H	OB	Androw C	. Donels	-	mo	DZ	1936		▶ JU	LY 21	, 1995			
	2	30, NAME AND ADDRESS OF PERSON WI							•					
		Andrew O. Donel	son, M.D. 91	.5 TO	LL HOUSE A	VENUE I	FREDER	ICK, M	ARYLAN	D 21	701			



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		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMENT	OF H	EALTH AND DEATH	MENTAL HYGI REG.					
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH	1	3. TIME OF OEATH			
		JEAN	ELIZABETH	E	DWARD	S		July 21.	1995	3:25 A	М		
T.		4. SOCIAL SECURITY NUMBER 216-18-1502	5. SEX 6. AGE ((In yrs. last birthday) YRS.	IF UNDER I	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Yea Feb 19,		8. BIRTHPLACE (State or Foreign Country)	7		
3 should	1	9a. FACILITY NAME (If not institution, give at	reet end number)	*	9b. CITY,	TOWN C	OR LOCATION OF D			INTY OF DEATH			
c,°	TOR	Memorial Hos	pital		Cu	mbe	rland		A1	legany			
permit. Pages 1,	DIRECTOR	WV Miner			ry, town or		TION			10d. INSIDE CITY LIMITS? 1 YES NO			
E e	AL	10e. STREET AND NUMBER					. ZIP CODE		10g. CIT	IZEN OF WHAT COUNTRY?	_		
ansit	FUNERAL	Route 2 Box 97				2	6753		USA	1			
BALTIMORE, MARYLAND 21215-0020 ser death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the burial-transit wal.	BY FUI	11. MARITAL STATUS 1 Never Merried 2X Married 3 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	-17	yes, sp	ENDENT OF HISPA acity Cuban, Maxic 2X NO Speci	NIC ORIGIN? (Specify an, Puerto Rican, etc. fy:	Yes or No-	14. RACE — American Indian, Black, Whits, atc. Specify:			
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LAND the hospital detached to once.	MPI	12		Homema	ker			Own 1	Home				
LAN the hor detach	S	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	AME (First, Middle, Mai	den Surname)				
RYL ed by uid be	BE	John Weaver						e (Logan)					
MAR retained 5 should notified	٩	19a. INFORMANT'S NAME (Type/Print)			_			Route Number, City or	Town, State, Zip	p Code)			
Page		Richard E. Edward					: Ridgel		26753		_		
ALTIMORE, death. Page 6 may be funeral director, page		20a. METHOD OF DISPOSITION **District Committee Committ		PLACE AND DATE	ther place)					City or Town, State			
Page al din		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	11crest			D ADDRESS OF FA		TIMETT	and, MD	_		
BALTIMORE after death. Page 6 may by the funeral director, pa moval.		> 4 ticholas,	1. Scarpa	Stř	Sca	arpe mbei	elli Fun cland, M	eral Home D 21502	:				
ompletely filled in the real	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. CAD - Dichewic Cardiopypally Due to (or as a consequence of):												
o cian be	CATION	Sequantially list conditions, if any, laading to immediata cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE O	F):								
P.O. P.O. P.O. P.O. P.O. P.O. P.O. P.O.	CERTIFIC	CAUSE (Disesse or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):								
E Se e	AL 0	PART II. Other significant conditions	contributing to death be	ut not reaulting	in tha und	erlying	cause givan in	Part I. 24a, WAS	AN AUTOPSY	24b. WERE AUTOPSY FINOIN	GS		
RECORD requires that the een signed by th of Health and M shows any inji	MEDIC) iabote	5						FORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	E		
E 5 6 5 E		DID TOBACCO USE CONTR	PIBLITE TO CALISE OF	E DEATH VI	:C [] N	OP	UNCERTAI	NI FI		1 🗆 YES 2 NO			
12 6 8 a	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEA			ONCERIAI	NU					
AN: T ifficate State	Sic	EXAMINER?	HOSPITAL:	atient 3 DOA	OTHER:		5 Residence	6 Other (Specify)					
OF V HYSICIA his certif with the vith the	Ě	27. MANNER OF OEATH	28a. OATE OF INJURY (Month, Day, Year)	28b. TIM		8c. INJU	JRY AT	28d. DESCRIBE HO	W INJURY OC	CURED			
NG PHYS fler this eath with	BY	Naturel 5 Pending Investigation	(Moral, Day, Today		- M		ES 2 NO						
TENDI TTENDI CTOR: A after d	E	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Speci	— At home, farm,	street, factor	ry, office		281. LOCATION (Stre City or Town, St	et and Number ate)	r or Rural Route Number,			
4 4 5 =	COMPLET	2 MEDICAL EXAMINER	EIAN: To the best of my knowless: On the basis of examination							ted. ne ceuse(a) and menner as stated			
TO THE HOSPIT TO THE FUNERA De filed within 7 IMPORTANT:	H	290. SIGNATURE AND TITLE OF CERTIFIER	with.				D 28910		29d. DAT	SHOWED (Month, Day, Year)			
/	٩	30. NAME AND ADDRESS OF PERSON WHO				ca1			July	71502			
6		31. OATE FILEO (Month, Day, Year)	32 REGISTRAR'S SIGNA His Havelon A	ATURE		1	Daug.	ompet Tall	, 140	41 JUZ			
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	certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attend	9
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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

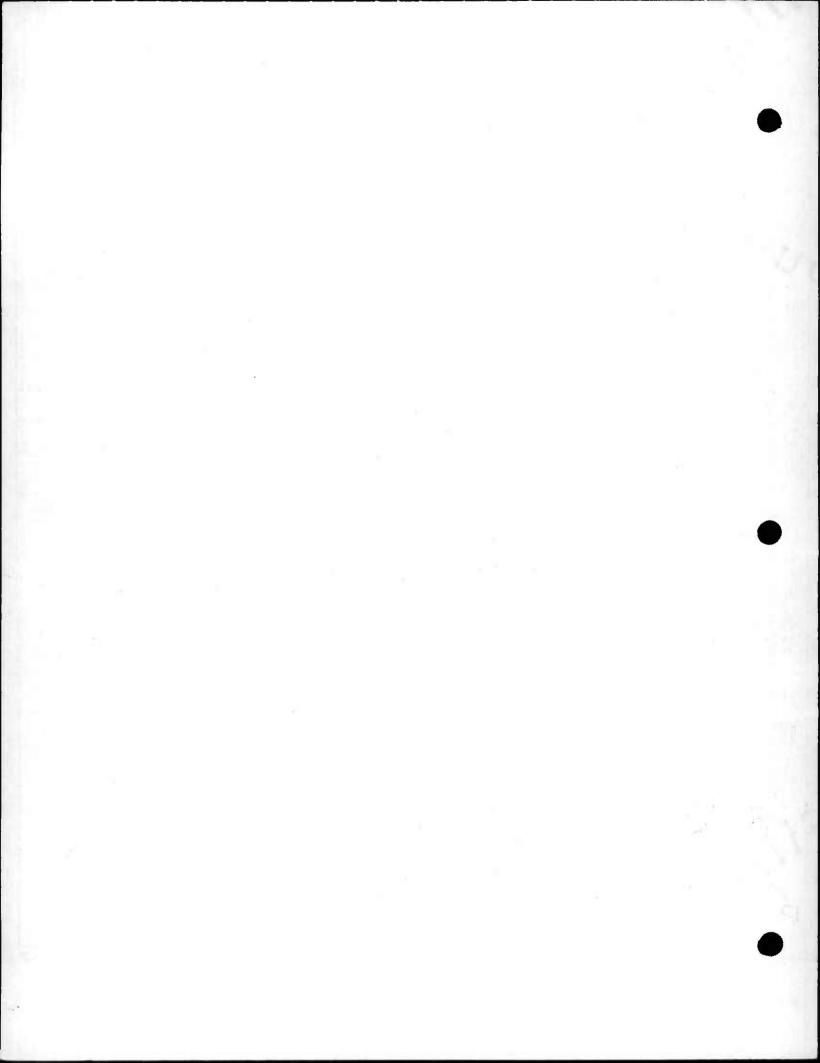
31. DATE FILED (Month, Day, Year)

191995

32. REGISTRAR'S SIGNATURE

Daviden Rodall

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle Lest) 2. DATE OF DEATH 3. TIME OF DEATH VEAR Wilbur Fletcher Merle 10:10 July 995 AM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year)
Feb. 2, 1 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 578-01-0854 1 😡 M 2 🗌 F 88 1907 llinois Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Lorien Nursing and Rehabilitation Ctr. Columbia Howard RESIDENCE OF DECEDEN 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Howard Columbia permit. 1 YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6336 Cedar Lane burial-transit 21044 USA 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES B 1 TYES 2 X NO Specify: Specify: 3 Widowed 4 Divorced the White as. COMPLETED 15. DECEDENT'S EOUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION use 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ō Elementary/Secondary (0-12) College (1-4 or 5+) 12 Salesman Dairy Products 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Alpheus Clark Fletcher Rosetta Baker BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Dorothy Α. Fletcher 6336 Cedar Lane Columbia, Md 21004 pe 20a. METHOD OF DISPOSITION
1 A Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Cemetery 7/19/95 Rockville, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W., Sil.Spr.MD 20901 n by the removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata 0 Intervel Batwean ripietery niled cremation, o **IMMEDIATE CAUSE (Finel** Oneat and Death or other traumatic event, the disease or condition Multiple Myelomas 6 Months resulting in death) DUE TO (OR AS A CONSEQUENCE OF): nding physician and corr Hygiene prior to burial, Neuropathy NO Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CERTIFICAT CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in daeth) LAST the atten Injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 TYES 2 TO NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 YES 2 X NO 1 Donatlant 2 ER/Outpetlant 3 DOA the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT this c 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked, 1 X Natural В 1 YES 2 NO After 1 2 Accident DIRECTOR: At hours after de Item 28 is r 3 Suicide 28a. PLACE OF INJURY — At home, farm, atreet, factory, offica building atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 9 8 Could not be 4 Homicide detarmined TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTI DE filed within 72 hours at IMPORTANT: If Item 2 COMPLET 29a. CERTIFIER 1 _ CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner as stated. GNATURE AND TUNE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE July 14, 1995 D 34868 0 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Steven H. Diener, M.D. 11055 Little Patuxent Pkwy., Suite 205, Columbia MD



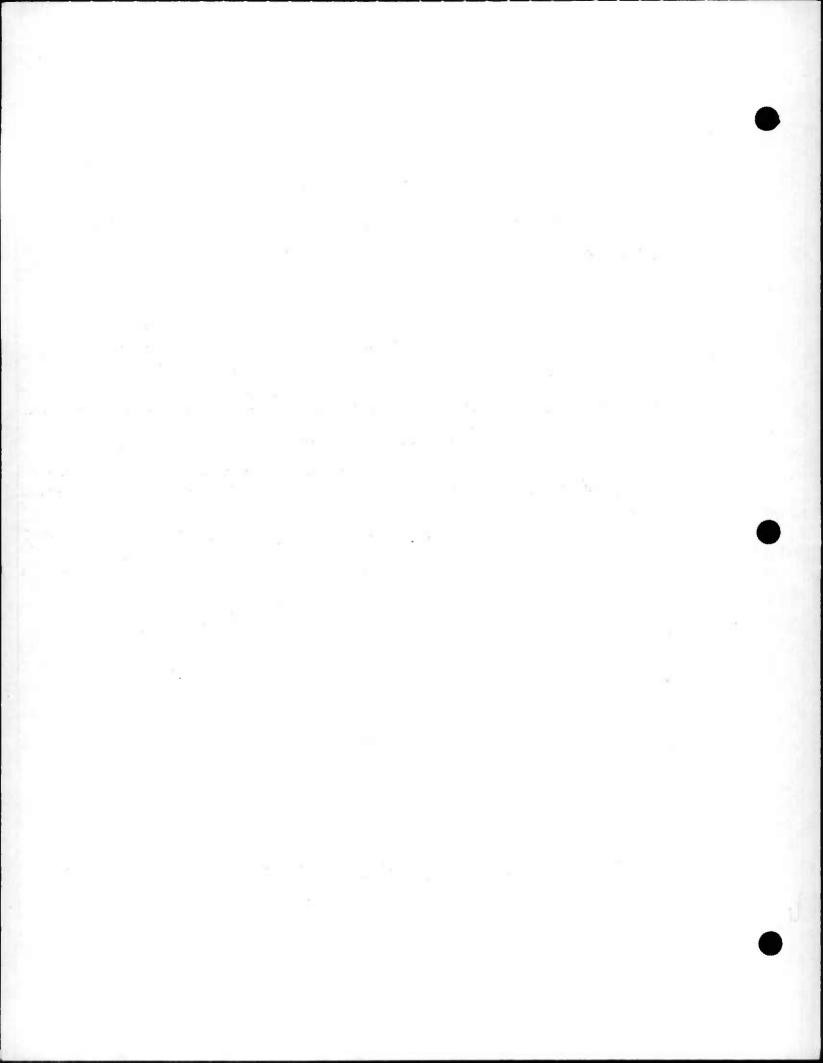
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_	_	1 - STATE REGISTRAR		STATE OF I	MARYLAND C	DEPARENTIF					MENT	AL HYGIEN				
	i	1. DECEDENT'S NAME (First, Midd	,								2. DA	TE OF DEATH	AV	YEAR	3. TIME OF DEATH	
	Н	BELLA FRUMA	FINK	ELSTEIN							JU.	ĽÝ 18,	1995	TEAR	5:30 AM	
		4. SOCIAL SECURITY NUMBER	- 1	5. SEX	6. AGE (In yrs. le	**		R 1 YEAR	IF UNDER		7. DAT	TE OF BIRTH		8. SIRTH	PLACE (State or Foreign	
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	ı	9e. FACILITY NAME (If not institution					9b. CIT	Y, TOWN	OR LOCATI	ON OF DE				NTY OF D	EATH	
6		HEBREW HOME	OF G	REATER V	VASHING1	ON	RO	CKVI	LLE				MON'	TGOME	ERY	
<u> </u> පූ		RESIDENCE OF DECEDE	COUNTY													
DIRECTOR				OMERY				OR LOCAT							10d. INSIDE CITY TELIMITS?	
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FUNERAL		1801 E. JEFF	ERSO	N STREET	r			101	20	852			-		TED STATES	
5		11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1	T EVER IN U.S. A	RMED	13.	WAS DEC	ENDENT C	F NISPAN	IIC ORIC	3IN? (Specify Yes	or No-	14. RACE	- American Indian,	
BY F	- 11	1 Never Married 2 KMerrie 3 Widowed 4 Divorced	bd	IF YES, GIVE V	AR OR DATES	NU			2 X NO			o Rican, etc.)			, White, etc.	
	V											WHITE				
哥		15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY												_		
빌		Elementary/Secondary (0-12)		College (1-4 or 5	-)						- 1.	ርጥልጥ ፑ ኮ	FDAR	TMENT	r	
once.		12 FILE CLERK STATE DEPARTMENT 17. FATNER'S NAME (First, Middle, Last)														
를 8		17. FATNER'S NAME (First, Middle, Last) MARCUS GOLDENBERG 18. MOTHER'S NAME (First, Middle, Meiden Surname) ROSE SCHEINERMAN														
B B		19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
[2		ARTHUR FINKELSTEIN (HUSBAND) 1801 E. JEFFERSON STREET #508-ROCKVILLE, MD. 20852														
8	ı	20s. METHOD OF DISPOSITION		111 (110)	77					DIK	-					
must be notified at once. TO BE COM	-	1 X Burtal 2 Cromation 3 4 Donation 5 Open Speci	☐ Remov	el from State	20b. PLACE	AND DATE (OF DISPO: IDRAPINGE	SITION /Na	me of		1		CATION —			
5	ŀ	21. SIGNATURE OF FUNERAL SER	_	- /	mi. I	LDAM	_				-	ZU ADE	LPHI	MAR	RYLAND	
examiner	1	22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.														
	┙	1170 ROCKVILLE PIKE - ROCK											CKVTI	LLEAN		
medical	ı	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dulor, such as complications are											est,	t, Approximate		
	Inten												Interval Between Onset and Death			
흪	1												5 DAYS			
event,	ı	disease or condition												1000		
		Taranana and Associa	b.	CERE	BROVA	CUL	AP	7	0158	EAS	57				MANTH	
or other traumatic	- {	Sequantielly list conditions, if sny, leading to immediate		DUE TO	(OR AS A CONSE	OUENCE O	F):									
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		that initiated events DUE TO (OR AS A CONSEQUENCE OF):														
히 监		resulting in deeth) LAST	d.													
	- 11	PART II. Other significent co	nditions	contributing to	death but not i	resulting	In the u	nderiving	Cause o	lven in i	Part I	24s. WAS AN	AUTOPSY	245	WERE AUTOPSY FINDINGS	
ws any inj EDICAL	ı									7 10 10		PERFOR	MED?	-	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
shows any inju	ı											1 TYES 3	NO		OF DEATH?	
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A B		25. WAS CASE REFERRED TO MED		BUIE IO CA		E OF DEAT			UNC	ERTAIN	4 LJ					
PHYSICIAN:		EXAMINER?	F	IOSPITAL:			QTHE	R:	-							
히		27. MANNER OF DEATN		Inpatient 2 = 28a, DATE OF		28b. TIM	_	28c, INJ		sidence (her (Specify)				
		1 Natural 5 Pendir	19	(Month, D			URY	WO	RK?	1 100	28G. D	ESCRIBE NOW I	NJUNY OCC	OURED		
		2 Accident Investi		28e. PLACE O	F INJURY — At he	me ferm s	treet for) NO	004.1.6	CATION (O	-146 -1			
28 IS		3 Suicide 8 Could 4 Nomicide determ		building,	etc. (Specify)	reding t		Jinici			C/I	CATION (Street a ty or Town, State)	iriu ryumber	ur muniti At	оин питові,	
	H	29e. CERTIFIER	127.0				100-	-								
ANT: If Item 28 is COMPLETED		(Check only 1 Chec														
S		2 MEDICAL EXAMINER: On the beste of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(a) and menner se stated.														
BE COMPLE		296. SIGNATURE AND TITLE OF CI	ERTIFIER	4			11.7	\Box	29c. LICE	NSE NUM			29d, DATI	E SIGNED	(Month, Day, Year)	
\$ ≥		20 NAME AND ADDRESS OF BERN	~	Ans.	2021	. 11	L	/	D	5	2 8	55	7	1/18	195	

DEATH (ITEM 27) (Type, Print)

STEVEN 31. DATE FILED (Month, MONTROSE ROAD, RUCKVILLE,

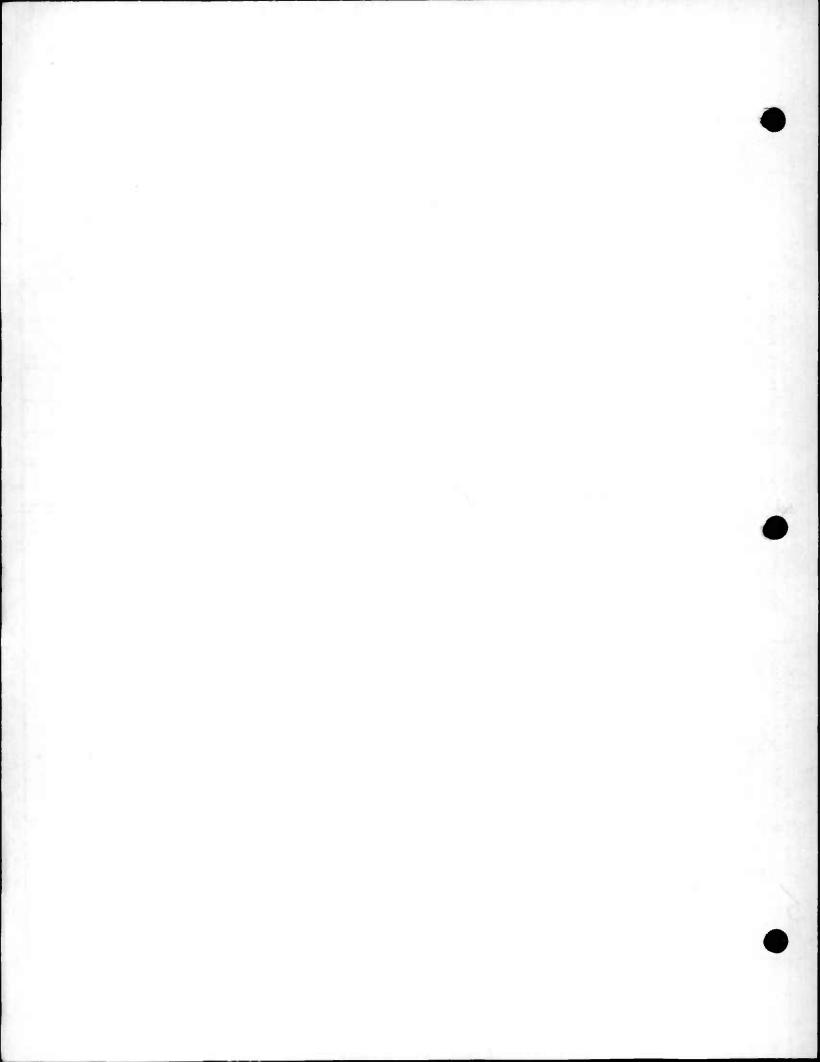
201995 32 REGISTRAR'S SIGNATURE
Julia Davelor Rawall



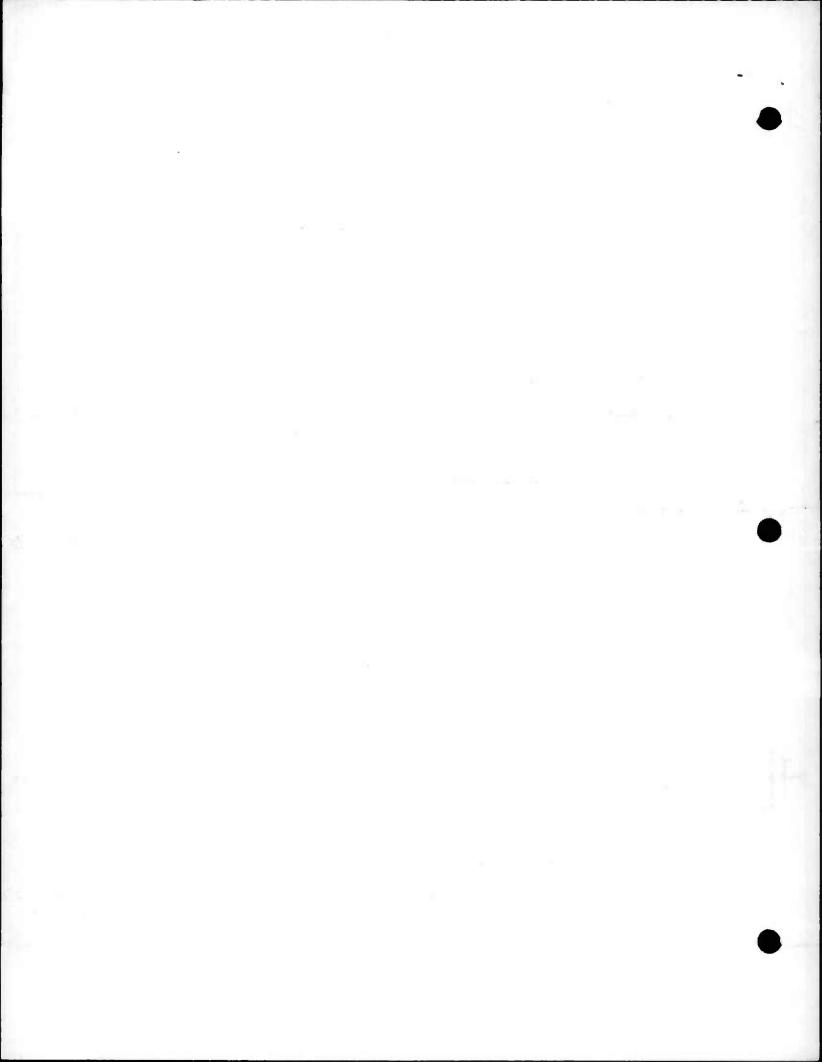
DIVISION OF VITAL RECORDS, P.O. BOX 68760, HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2s, mountains.

	2 3 chould	E. S. Should	
	Parise 1	2000	
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CIARL	Liraneit	5	
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ILS ARTEL	n by the	removal	ic event, the medical exami
74 1100	ly filled i	ation, or	the m
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dolles n	n signed	f Health	OWS an
a MAN	has bee	Dept. o	item 23 shows a
TOTOTAL II	ertificate	the State	or iten
io ra ra	er this ce	th with t	arked,
ENDIN	TOR: Afte	ifter deal	E IS IS
TO THE HUSTING ON ALLENDING PHISIC	TO THE FUNERAL DIRECTOR: After this certificate has been	Pours :	Item 2
NOSLI N	FUNERA	within 72	TANT: II
משור מו	THE L	pe filed	MPOR

	FOR 1 - STATE REGISTRAR		STATE OF M	MARYLAND	/ DEPAR CERTIF	RTMENT	T OF I	HEALTH DEA	AND I		YGIENE	. · · ·	, la	.0046	
	1. DECEDENT'S NAME (Flist TATIANA	, Middle, Last) (NM)	N)		FESSE					2. DATE OF DEATH NONTH DAY YEAR JULY 12 1995 11:15A					
	4. SOCIAL SECURITY NUMBER 098-26-117		5. SEX 1 M 2 X F	6. AGE (In yrs.		IF UNDER	DAYS	IF UNDER	1 24 HRS.	7. DATE OF BI	DTH	Т	8. BIRTH Countr	PLACE (State or Foreign	
~	9e. FACILITY NAME (If not in					9b. CITY	, TOWN	OR LOCATI	ON OF DI			9c. COUN			
CTO	Friends Num	rsing	Home			San	dy S	Sprin	gs			1	lont	gomery	
DIRECTOR	10a. STATE	10b. COUNT				Y, TOWN (^					10d. INSIDE CITY LIMITS?	
	100. STREET AND NUMBER	п	one		wa	snin		t. ZIP COD				10g. CITIZ	ZEN OF W	1X YES 2 NO	
FUNERAL	3016 Q St., S.E. 20020 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMDENT OF HISPANIC ORIGINAL STATUS											U.	S.A		
F	11. MARITAL STATUS 1 Never Married 2 🔀	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2 X	ARMED NO		If yea, sp	CENDENT Concept Cube	n, Maxica	IIC ORIGIN? (Sp n, Puarto Rican,	ecify Yea (or No-	Black	— American Indien, , White, atc.		
D BY	3 Widowed 4 Divo	rced							Specin					ite	
ETE	(Specify only Elementary/Secondary (0	y highest grade	completed) College (1-4 or 5 a		DECEDENT'S (Give kind of life. Do NOT u	work done se retired.)	CCUPATI during m	ON ost of workin	ng	16b. KIND	OF BUSI	NESS/IND	USTRY		
5+ librarian Library of Congress												ress			
8	77. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surmame) Paul Sviatenko Natalia Boyarsky														
TO BE	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
Andrew V. Fessenko 3016 Q St., S.E., Wash., D.C. 20020															
	1 Souriel 2 Cremation 4 Donation 5 Other	n 3 🗆 Rem	oval from State	cemetery, c	ematory or o	of dispos ther placel ek C	eme t	ery	Ju1	y 14,9	5 Was	shing	aty or To	wn, Stata D.C.	
	22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home														
	22.22 Wisconsin Ave., N.W., Wash., DC 20007														
	IMMEDIATE CAUSE (Fin disease or condition resulting in death)	olt lallule.	rial out oue cen	se on each III	ne.					an cerdlec o		atory arre	eet,	Approximate Interval Between Onset and Deeth	
CERTIFICATION	Sequentielly list conditi if any, leeding to immed ceuse. Enter UNDERLY!! CAUSE (Disease or inju- that initiated evente resulting in death) LAST	flete NG ry	DUE TO	OR AS A CONS	EOUENCE OF	F):	U18	15						20415	
PHYSICIAN: MEDICAL	PART II. Other significer		e contributing to	death but not	resulting i	in the un	deriyin	g cause g	plven in		WAS AN AI PERFORM YES 2	ED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
ICI/	25. WAS CASE REFERRED TO EXAMINER? 1 ☐ YES 2 D NO	MEDICAL	HOSPITAL:			OTHER	1 :			ck only one)					
НХ	27. MANNER OF DEATH		28e. DATE OF	INJURY	28b. TIM	E OF	28c. INJ	URY AT	eldence	8 Other (Spec 28d, DESCRIBE		JURY OCCI	JRED		
BY F		Pending restigation	(Month, De	mere:		M	1 🗆	YES 2	NO						
											oute Number,				
COMPLETED			CIAN: To the best of ex											and manner as stated.	
BE	290. SIGHAPONE AND TITLE	OF CENTRES	e da	2 /	11/	1		29c. LICE	NSE NUM	BER	1	29d. DATE	SIGNED	(Month, Day, Year)	
2	36. HAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E DEATH (IT	EM 27) (Type.	Print)		PI	4	58		201	1412	1184	
	Thomas E	. Dool		7			a A	ve.,	#304	4, 01ne	v. M	ID 2	0832		
	31. DATE FILED (Month, Day, 1) JUL 18		32. REGISTRAI	S SIGNATURE							7.3 44		JU-17		



	1 - FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF			NTAL HYGIEN	E			
	1. OECEOENT'S NAME (First, Middle, L AIBER+	E, Fra	ntum			2.	DATE OF DEATH DA		YEAR 25	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	5. SEX	E (In yrs. last birthday)	IF UNDER 1 YEA			DATE OF BIRTH	T	s. BIRTHP Country	LACE (State or Foreign	
	214-01-1914	87 YRS.	MONTHS DAY	S HOURS	MIN. 1	(Month, Day, Year) 11/9/1907			yland		
-	9a. FACILITY NAME (If not institution,			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN							
CTOR	Carroll Luth		Care	West	minst	er		С	Carroll		
1 2	10e. STATE 10b. CO		10c. CI	Y, TOWN OR LO	CATION				Т	10d. INSIDE CITY	
DIRE	MD C:	arroll	We	estmin	ster		1 X YES 2 NO				
3ĕL	10e. STREET AND NUMBER				101. ZIP CODI	E		10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	205 St. Mark				2115					States	
	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER FORCES? 1 X YE	S 2 NO	13. WAS	DECENDENT O specify Cubs	F NISPANIC (n, Mexicen, P	ORIGIN? (Specify Yes ruerto Ricen, atc.)	or No-	14. RACE Black,	- American Indian, White, etc.	
B	3 Wildowed 4 Divorced	DATES	10	ES 2 X NO	Specity:		Specify: White				
<u> </u>	15. DECEDENT'S (Specify only highest of	EOUCATION grade completed	18e. DECEDENT'S	USUAL OCCUP	ATION	_	16b. KINO OF BUS	INESS/INOL	USTRY		
9	Elementery/Secondery (0-12)	College (1-4 or 5+)	life. Do NOT u	se retired.)		g					
once.	12		elec	tricia	7			_	avy	research	
400	17. FATHER'S NAME (First, Middle, Last Samuel T.	Frantum					(First, Middle, Maiden	-			
	190. INFORMANT'S NAME (Type/Print)	Flancum	105 MAII INC	ADODESS (Sam		lna	Elizab Number, City or Town			camer	
2	Lillian B. F.	rantum								minster, N	
examiner must be notified	20e. METHOD OF DISPOSITION	2	Ob. PLACE AND DATE	OF DISPOSITION				ATION - C			
E I	1 X Burlel 2 Cremetion 3 4 Donetion 5 Other (Specify)	, ·	ornerory, ordinatory or t	mer prace,							
ine	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Moreland Memorial Park Baltimore, MD 22. NAME AND ADDRESS OF FACILITY Prints Funeral Home & Chancel										
exau	Katherine Rids - Sweiter Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD										
medical	23. PART I. Enter the diseases,	a cardiac or reapi	ratory arre	est,	Approximata						
	ahock, or heart fellure. Liet only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death										
vent, the	disease or condition - arcin and Lung										
even	DUE TO (OR AS A CONSEQUENCE OF):										
jury, or other traumatic event,	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):										
TA TA	cause. Enter UNDERLYING										
the IFI	CAUSE (Disease or Injury Due TO (OR AS A CONSEQUENCE OF):										
ry, or other traumatic	resulting in death) LAST	d									
Injury, AL CE	PART II. Other algniffcant cond	Itiona contributing to death	but not reaulfing	In the underly	Ing cause o	Iven In Par	t I. 24s. WAS AN	AUTOPSY	24b. 1	WERE AUTOPSY FINDINGS	
≥ 0	ono		est ha	. 0	-		PERFOR			WAILABLE PRIOR TO COMPLETION OF CAUSE	
shows a	abla		0				1 🗆 YES 2	NO.		OF OEATH?	
23 sh AN: P	DID TOBACCO USE CO	NTRIBUTE TO CAUSE	OF DEATH Y	S NO	M UNC	ERTAIN [
ed, or item 23 s PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER?	HOSPITAL:	26. PLACE OF DEA		ne)						
or it	1 🗆 YES 2 NO	1 Inpatient 2 ER/Ou	utpetient 3 DOA			eldence 6	Other (Specify)				
P. P.	27. MANNER OF DEATN Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year,		JURY	INJURY AT WORK?		d. DESCRIBE HOW IN	JURY OCC	UREO		
B	2 Accident Investigat	28a PLACE OF IN ILLI	RY — At home, ferm,		YES 2	-	4.4.00477044.00	- 1 11 - 1 -			
28 is TED	4 Homicide 6 Could not datermine	building, etc. (Sc	pecify)	etreet, rectory, c	THE O	26	f. LOCATION (Street a City or Town, State)	na Number (or Hurai Ho	ute Number,	
COMPLETE	290. CERTIFIER CERTIFYING P	HYSICIAN: To the best of my kno	rulados deeth assure	ad at the time of	ets and also						
T. II		Milleri: On the bests of examinat								and manner se stated.	
	286. SIGNATURE AND THE OF CERT		1			NSE NUMBE				Mont Day, Year)	
MPOR O	AX.	arica	to n	NE)	1) Q1	0/0	▶ '7	12	2 95	
₹ 2	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE OF E	DEATH (ITEM 27) (Type	. Print)		10	1	- 4	+~	71791-11	
	J. W. CA	RICOFEE	MO	4. C), R.	111	12Uni	You	SR	71791-11	
1	31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIG			,			, '9		J	
	JUI 24 1995 A	whi a kurder Real	211								



3. TIME OF DEATN

a M

9:25

6. BIRTNPLACE (State or Foreign

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

white

YES 2 NO

Approximate

Interval Between

Onsst and Death

one week

10 years

5 years

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATN?

1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

PA

10g, CITIZEN OF WHAT COUNTRY?

Specify:

9c. COUNTY OF DEATH

ALLEGANY

REG NO

DAY

1995

USA

2. DATE OF DEATH

WALTER FUSE July 19, Ε. 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 5. SEX 6. AGE (in yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS 114-12-2439 1X M 2 | F 77 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR CUMBERLAND MEMORIAL HOSPITAL RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Allegany Cumberland permit. FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE page 5 should be detached for use as the burial-transit 36 New Hampshire Avenue 21502 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 15 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or Noif yee, specify Cuben, Maxicen, Puerto Rican, etc.)
 \(\subseteq \text{YES 2} \subseteq \text{NO} \)
 Specify: BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried 3 Widowed 4 □ Divorced BY II WW COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY (Give kind of work done ife. Do NOT use retired.) ntary/Secondary (0-12) College (1-4 or 5 +) 12 Steelworker Steel Company 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) H John Fuse BE Julia (Kraskow) notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Berwanger <u>Melinda J.</u> 86 New Hampshire Avenue; Cumberland, MD pe 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must funeral director, Cramatory or other place)
Mary's Cemetery 4 Donation 5 Other (Specify) 07/21 Cumberland, MD medicai examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD filled in by the ion, or removal. the 21502 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liet only one cause on each line 10 IMMEDIATE CAUSE (Fine) a e disease or condition resulting in death) nemonia completely other traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): een signed by the attending physician and control of Health and Mental Hygiene prior to burial, CERTIFICATION Sequentially liet conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediata cause. Enter UNDERLYING OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events PART II. Other significant conditions contributing to death but not reculting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL shows any 1 TYES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES YOU UNCERTAIN certificate has been the State Dept. (23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) Item HOSPITAL: 1 TYES 2 TANG 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) marked, or 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 26d. DESCRIBE NOW INJURY OCCURED this c 1 Natural 5 Pending 1 YES 2 NO BY After death 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 26f. LOCATION (Street end Number or Rural Route Number, City or Town. State) 90 8 Could not be COMPLETED FUNERAL DIRECTOR: within 72 hours after 4 Nomicide 28 item 1 CERTIFYING PNYSICIAN: To the best-of, my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated. THE HOSPITAL O THE FUNERAL D filed within 72 ho TO THE FUNERAL ITO THE FUNERAL ITO THE FUNERAL ITO THE MICHIN 72 h 2 MEDICAL EXAMINER: On the beels of e nation end/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(s) and manner ee stated. 29b. SIGNATURE AND TITLE OF CENT 29c. LICENSE NUMBER 8 D 36766 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) Dr. Vic Poonai-955 Frederick Street-Cumberland, MD 21502

Dir Tavaler hard

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

0

31. DATE FILED (Month, Day, Year)

1. DECEDENT'S NAME (First, Middle, Last)

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Menial Hygiene prior to burial, cremation, or removal. IMPORTANT: If them 28 is marked, or teem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
BALTIMORE, MARYLAN bours after death. Page 6 may be retained by the hilled in by the funeral director, page 5 should be detail, or removal.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Pages 1, 2, 3 should

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	t. DECEDENT'S NAME (First, Middle, List) 2. DATE OF DEATH S. TIME OF DEATH MONTH DAY YEAR														
	DANIEL	JAC	OB	FOLK	Jr.					MONTH DA					
	4. SOCIAL SECURITY NUME	est birthday)	IF UNDE	R 1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH	1PLACE (State or Foreign							
	214-28-6465	1 🔀 M 2 🗌 F	67	YRS.	MONTHS	DAYS	HOURS	MIN.	June 10, 19	28	Count	ryland			
Œ	9a. FACILITY NAME (If not in Sacred Hear					9b. CITY		OR LOCATI		ATH		JNTY OF D			
DIRECTOR	RESIDENCE OF DEC		DITAL			Cumberland Allegany							any		
\(\text{H}\)	ton. STATE	tob. COUNTY	1		10c. CI1	Y, TOWN	OR LOCA	TION					tod. INSIDE CITY		
	Maryland Allegany						Fro	stbur	g				t X YES 2 NO		
FUNERAL	10e. STREET AND NUMBER					tor. ZIP CODE					tog. CITIZEN OF WHAT COU				
<u> </u>	179 Mt. Pl	.easant			21532						A.				
BY FU	t Never Married 2 3 Widowed 4 Divo		IF YES, GIVE V	YES 2	NO		If yes, sp	ENDENT Code	n, Maxica	IIC ORIGIN? (Specify Yea n, Puarto Rican, etc.)	or No	t4. RACI Blaci Spec	E — American Indian, k, Whita, atc.		
ED	ts. DEC	EDENT'S EDU	CATION		ECEDENT'S	USUAL O	CCUPATION	ON		16b. KIND OF BUS	INE CC /IN	OHETEV	White		
E	(Specify only Elementary/Secondary (0	y highest grade I-12)	College (1-4 or 5		Give kind of le. Do NOT u	work done	during mo	st of working	ng	TOOL KIND OF BOX	ME 337 IN	DOSINI			
COMPLET	11			"	Dri	ver				Un	iver	sity			
00	17. FATHER'S NAME (First, M									ME (First, Middle, Maiden	Sumame)				
BE	Daniel Ja		Folk	Sr.				Ve	ra	Elizabet	h K	insi	nger		
5	charlotte F									et Frostbu			21532		
	20a. METHOD OF DISPOSITI	n 3 🗆 Rame	oval from State	20b PLACE	AND DATE	OF DISPOS	SITION /N	ame of		DATE 200 LO	CATION	City or To	Str. or Town State		
	4 Donation 5 Other 2t. SIGNATURE OF FUNERAL		ENSEE	rrost	burg	Memo	rla	L Par	k Ju	Ly 24,95 F	rost	burg	urg, Maryland		
	> Joh	nK	Dur	4		5	7 F1	rost	Aven	ue Frostbu	uner rg,	al H [aryl	ome and 21532		
	23. PART I. Enter the diseases, or complicatione that coused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest,														
	Inter IMMEDIATE CAUSE (Finel												Interval Between Onset and Death		
	disease or condition resulting in death) s. Myocardial lufarction, DUE TO (OR AS A CONSEQUENCE OF):											30 min1			
NO	Sequentially list conditions, If any leading to immediate DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):														
Ě	If any, leading to Immediceuse. Enter UNDERLYI														
임	CAUSE (Disease or Inju	ry 🕻	DUE TO	(OR AS A CONSE	TEBRILLATION CONSEQUENCE OF:								345		
CERTIFICATION	resulting in deeth) LAS	T L	I diepartice Hyperprophic SUB antic STOROS'S							344.					
	PART II. Other significe	nt condition	contributing to	deeth but not	reaulting	In the ur	nderlying	g ceuee g	iven in	Pert I. 24a, WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS		
MEDICAL										PERFORMED?			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
M										_ _ ′			t TYES 2 NO		
ž	DID TOBACCO U		RIBUTE TO CA					UNC	ERTAIN	1 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEOICAL	HOSPITAL:		CE OF DEA	TH (Check	,,								
14S	1 YES 2 NO		1 Inputient 2	ER/Outpetlant	1	4 🗆 Nur	sing Hom		aldence	6 Other (Specify)					
BY P	1 Natural 5 🔲 I	Pending nveatigation	28a. DATE OF (Month, D	lay, Ybar)	2ab. TIM	E OF URY M		URY AT PK? YES 2	NO	28d. DEŞCRIBE HOW IN	JURY OC	CURED			
	3 Suicide a Could not be datarmined 28a. PLACE OF INJURY — At hom building, atc. (Specify)					me, farm, streat, factory, office 28t. LOCATION (Sin City or Town, St					eet and Number or Rural Route Number, tate)				
PLE	29a. CERTIFIER (Check only	IFYING PHYSIC	CIAN: To the best of	my knowledge, d	eath occurr	ed at the t	lme, data	and place,	and dua	to the cause(s) and men	nor an ata	ted.			
COMPLETED	one) 2 MEDI	CAL EXAMINE	R: On the beats of a	xamination and/or	investigatio	n, In my o	opinion, d	eath occur	ed at the	time, data and place, and	d due to ti	ha cause(a) and manner as stated.		
出	296. SIGNATURE AND TITLE	OF CERTIFIER	es / Es	que l	00	10		29c. LICE	NSE NUM	BER 66			(Month, Day, Year) 2,2,1995		
٥	30. NAME AND ADDRESS OF	4.8			EM 27) (Type)		70	21)	To	mace F					
	3t. OATE FILED (Month, Day, 1			A'S STONATURE	4 7	To	10	111	12	race 1	rus	Mus	2/521		
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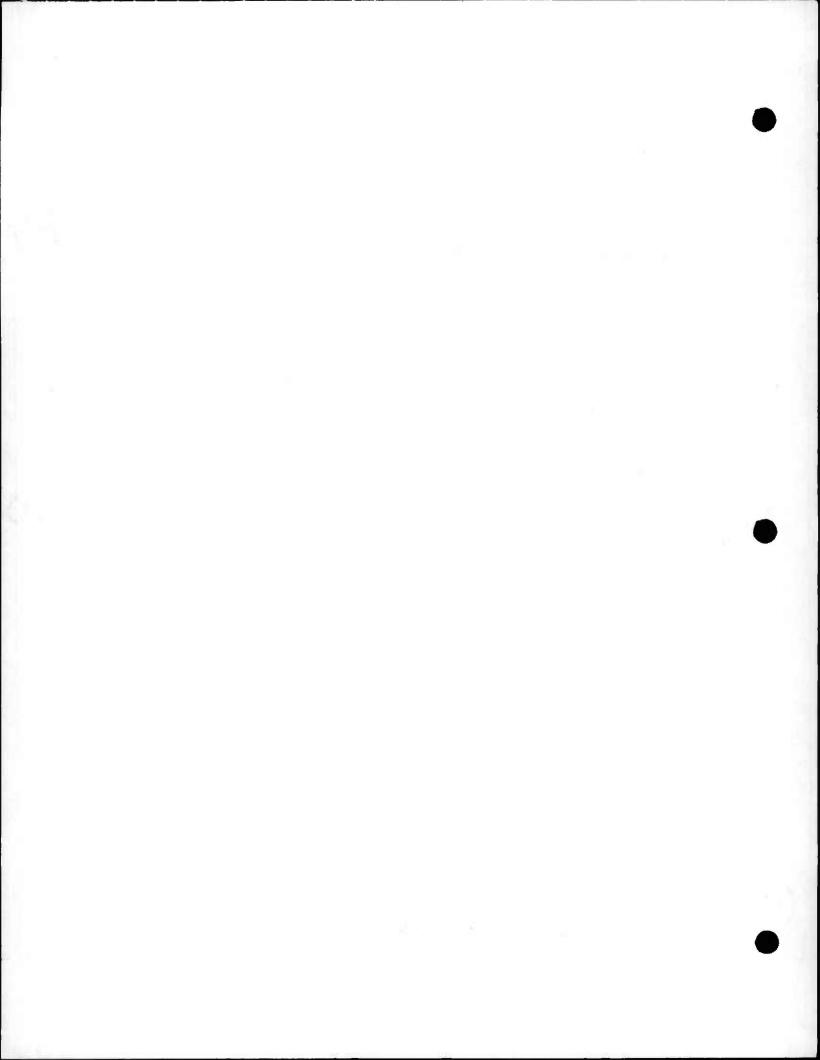
95 23347 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Charles E. Fletcher, Sr. July 16, Mg95 2:30a. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Oct. 18,1919 213-16-2086 HOURS 1 🛛 M 2 🗌 I 75 YRS. Maryland 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 12914 Old Fletchertown Road Prince George's Bowie RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Bowie XX YES 2 NO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 12914 Old Fletchertown Road 20720 United States 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, DIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indien, Black, White, atc. 1 Never Married 2 XXMarried If yes, specify Cuben, Mexicen, Puerto Rican, etc. ВҮ 1 YES 2 NO Specify: Specify 3 Widowed 4 Divorced WW II Yes No Black. COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 8 +) Supervisor US Postal Service 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James Walter Fletcher Carrie Barrios BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Bertha P. Fletcher Same as #10. 20a. METHOD OF DISPOSITION
1 To Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Ascension Church Cemetery 7/19 Bowie, MD 21. SIONATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert Robert E. Evans Funeral Home, P.A. MA nes 16000 Annapolis Rd. Bowie, MD 20715 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart fallure. List only one cause on each line. Interval Batw IMMEDIATE CAUSE (Final Onset and Deeth disease or condition Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF): resulting in death) COTOTAM ATTEMY DISCUSSED DUE TO (OR AS A CONSEQUENCE OF): myocardial infarction CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or Injury that initiated events Chronic Obstructive Pulmorray resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO 1 ☐ YES 2 ☐ NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 MO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 X Realdence 8 - Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the ceuse(e) and manner ee stated. 2 ___ MEDICAL EXAMINER: On the besie of exemination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Yesr)

July 17, 1995 29c. LICENSE NUMBER BE *achelle M. alchon D44196 (Mary and)

Bowle,

MD

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print, 14300 Gallant Fox 31. DATE FILED (Month, Day, Year) 191995



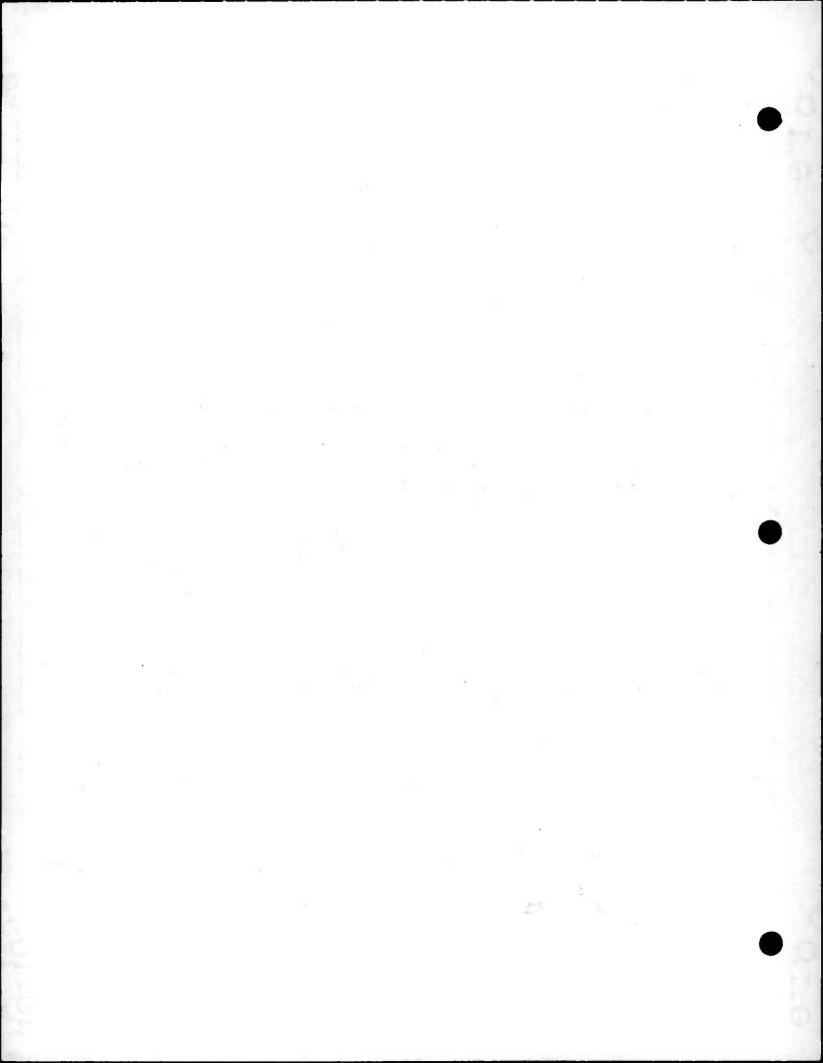
DIVISION OF VITAL RECORDS, P.O. BOX 68760

FOR STATE REGISTRAR REG. NO. 1. DECEDENT'S NAME (First, Middle, Last 3. TIME OF DEATH 2. DATE OF DEATH BUMA 6 201 95 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. S. BIRTHPLACE (State or Formier 1 🔀 M 2 🗌 F 203-18-2985 YRS. Sept. 74 1920 PA Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Suburban Hospital Bethesda Montgomery RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Montgomery Bethesda permit. 1X YES 2 NO FUNERAL 10a. STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 5208 Ventnor Road funeral director, page 5 should be detached for use as the burial-transit 20816 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuben, Mexican, Puerto Ricen, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 NO 1 Never Married 2 Married BY Specify: 3 K Widowed 4 ☐ Divorced WW II White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
Above during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 4 + Veterans Administration Lawver once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) notified at Samuel W. Gibb Mary Chapman BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Nancy G. Crowley 12868 Mead Landing Court Jacksonville, FL 32223 pe 200. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must 1 Buriel 2 Cremation 3 Ren 4 Donation 5 Other (Specify) Mount Comfort Crematory Alexandria 7/21 VA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons 5130 WI Ave. NW Washington, D.C. 20016 the medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. signed by the attending physician and completely filled in by Health and Mental Hygiene prior to burial, cremation, or remo Approximate Interval Between IMMEDIATE CAUSE (Finel Onset and Death event, the disease or condition resulting in death) NO. Mer executed with DUE TO (OR AS A CONSEQUENCE OF dual traumatic amon CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate OR ATTENDING PHYSICIAN: The law requires that the death certificate be cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying ceuse gives MEDICAL 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH? PERFORMEO? any YES 2 -M shows a 1 YES 2 NO t, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES NO [certificate has being the State Dept. UNGERTAIN [23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (C) Hem 1 TYES 2 100 ent 2 ER/Out 4 ☐ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify) 6 27. MANNER OF DEATH 28e, DATE OF INJURY (Month, Day, Year) this c marked, 28± INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO В After 1 death 2 Accident 28e. PLACE OF INJURY -- At he Suicide 281. LOCATION (SHAIL A) DIRECTOR: A hours after d .60 ETED. od Number or Rural Route Number 4 | Homicide 28 Item Item 29a. CERTIFIER COMPL 1 CERTIFYING PHYSICIAN: To the pest of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL (
be filed within 72 h
IMPORTANT: It It HOSPITAL 2 MEDICAL EXAMINER Investigation, in my opinion, death occured at the time, data and placa, end due to the ceuse(e) end manner ee stated. 29c. LICENSE NUMBER BE 29d, DATE SIGNED AN 2 5480 WISCONN 31. DATE FILED (Month, Dey, 21 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DHMH-16 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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to the Hospital or Attending Phy	TO THE FUNERAL DIRECTOR: After this certifical be filed within 72 hours after death with the Sta	MONDTANT: 14 them 20 to market
SPITAL	WERAL III 72 I	12 16
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5	17 0 ac	Q.

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	1 - FOR STATE REGISTRAR		STATE OF N	IARYLAND /	DEPAR ERTIF	TMEN	OF H	EALTH DEAT	AND I	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First,	1. DECEDENT'S NAME (First, Middle, Last) Dorothy Muriel Gropp 2. Date of Death July 18, 1995 YEAR									3. TIME OF DEATH			
f	4. SOCIAL SECURITY NUMB	DOPOTRY 5. SEX	Muries 6. AGE (In yrs. las		OPP IF UNDER	1 YEAR	IF UNDER	24 MDS	JULY 18,	1995	a Burrur	10:07А. м		
1	578-44-705	6	1 🗆 M 2 💢	88	YRS.	MONTHS	DAYS	HOURS	MIN.	May 27,	1907	Country	PLACE (State or Foreign 1Sas	
1	9a. FACILITY NAME (If not in:	reet and number)	et and number)			, TOWN O	R LOCATIO	ON OF DE			NTY OF DE			
OR	Doctor's	s Hosp	ita1			La	nhan	1			Pri	ince	George's	
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY			10c. CIT	Y. TOWN (OR LOCAT	ION						
	Maryland	Prin	ce Georg	e's			ıbel						10d. INSIDE CITY IMITS? 1 YES 2 NO	
FUNERAL	6H Crescen	t Road						ZIP CODE 2077(HAT COUNTRY? States	
ВУ	11. MARITAL STATUS 1 Never Married 2XXX 3 Widowed 4 Divo		12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	T EVER IN U.S. ARI YES ZON	MED IO		If yes, spe	ENDENT O	n, Maxica	IIC ORIGIN? (Specify Yen, Puarto Rican, etc.)	s or No-	14. RACE Black, Specify	- American Indian, White, etc. White	
	15. DECI (Specify only	EDENT'S EDUC	ATION completed)	18a. DE	CEDENT'S	USUAL O	CCUPATIO	N at of workin		16b. KIND OF BU	SINESS/IND	DUSTRY		
COMPLETED	Elamentary/Secondary (0-		College (1-4 or 5 +) }	ive kind of to Do NOT us ibras		ourng mod	it or working	9	National	Counci	ling o	on the Aging	
BE CON	17. FATHER'S NAME (First, MI Simpson						er's NA	ME (First, Middle, Maider a Long	Surname)					
10	Anne Megl			198	2E We	ADDRES: Stwa	S (Street ar BY G1	eenk	or Rural F	Poute Number, City or Toy , Maryland	vn, State, Zip 1 20	770		
	20a. METHOD OF DISPOSITION 1 Burdal Married Ma													
	22. NAME AND ADDRESS OF FACILITY Donald V. Borgwardt Funeral Home, 4400 Powder Mill Rd. Beltsville,													
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart fallure. List only one cause on each line.													
	IMMEDIATE CALLES (Class)										Opent and Death			
	resulting in death)		DUE TO (OR AS A CONSEQUENCE OF): Ty Ocardial Defarition 2 Days										favores.	
Z	Sequantially list condition	one C b		/	W.	20	ar	œ	al	Refur	etro	25	2 Days	
ATIO	If any, laading to immed cause. Entar UNDERLY!!	ilata	DUE TO	OR AS A CONSEC	DUENCE OF	F):								
FIC	CAUSE (Disease or Injur		DUE TO	OR AS A CONSEC	DUENCE OF	7:								
ERTIFICATION	resulting in death) LAS1													
IL C	PART II. Other significar	nt conditions	contributing to	death but not re	aaulting i	n tha un	darlying	cause g	lven in			24b. 1	WERE AUTOPSY FINDINGS	
PHYSICIAN: MEDICAL	1ex	wic	Court	rever	nic	E, X	4/	ert	eun	PERFO	2		AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
ME									_			1 1	1 - YES 2 XONO	
ä	DID TOBACCO US		IBUTE TO CA					UNC	ERTAIN	۷ 🗆			,	
SIC	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:		E OF DEAT	H (Check								
HYS	1 YES 2 NO		1 Inpatiant 2 S		DOA 28b. TIM		ing Home		aldenca	6 Other (Specify)	IN ILIEN OC	CURED		
BY PI		Pending nvestigation	(Month, Da		INJ		WOF	HK?	NO	28d. DESCRIBE HOW INJURY OCCURED				
	3 Suicida 8 C	Could not be	28a. PLACE Of building, a	28a. PLACE OF INJURY — At homa, tarm, streat, factory, offica building, atc. (Specify)									ute Number,	
7	29a. CERTIFIER 1 CERTI	FYING PHYSIC	IAN: To the best of a	my knowledge, des	rth occurre	d at the ti	me, data a	nd placa.	and dua	to the cause(a) and me	Oper se stet	and .		
COMPLETED										time, data and placa, ar			and manner as stated.	
BE C	29b. SIGNATURE AND TITLE	OF CERTIFIER		ME			Т	29c. LICE				7.49 50	Month, Day, Year)	
10 B	VI		un te	(4)				De	75	572	17	1/15	4/85	
⊢ (30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH /ITEM	1 27) /Time	Orient1						7		

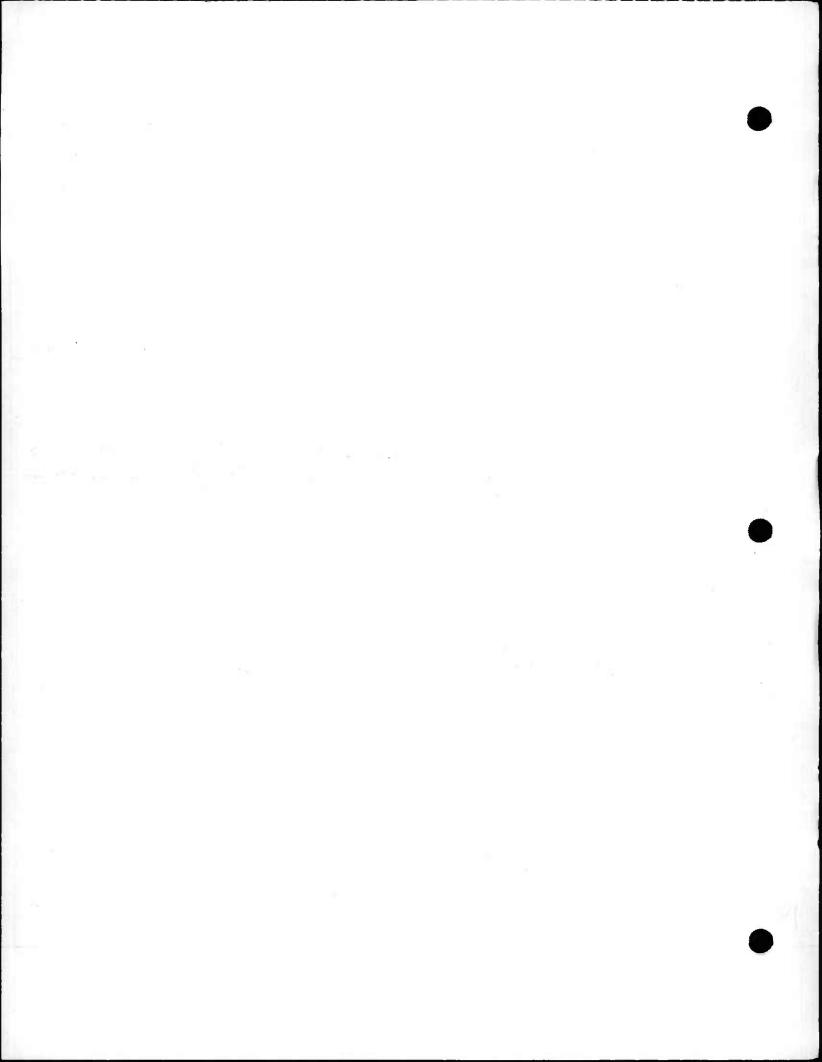
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE
Julia Davislor Randall

31. DATE FILED (Month, Day, Year)

JUL 20 1995

greenbert, no 20770



Pages 1, 2, 3 should hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burlal-transit permit. once. TE notified e must examiner filled in by the foot, or removal. other traumatic event, the medical cremation. completely requires that the death certificate be executed been signed by the attending physician and com it, of Health and Mental Hygiene prior to burial, 20 injury, has be HOSPITAL DR ATTENDING PHYSICIAN: The law 23 this certificate h marked, or the After TO THE HOSPITAL DR ATTENDIN TO THE FUNERAL DIRECTOR: Af be filed within 72 hours after de IMPORTANT: If Item 28 is in item 28 is

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

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BALTIMORE, MARYLAND 21215-0020

23350 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH JULY 16, 1995 ALEJANDRO GARCTA GARCIA 15:18 P 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (in yrs. last birthday) 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. S. BIRTNPLACE (State or Foreign 216-25-5151 DAYS HOURS 1 XM 2 F Feb. 21, El Salvador 1944 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR SHOCK TRAUMA UNIT BALTIMORE 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Rockville Montgomery 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 504 First Street 20851 El Salvador 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or Noif yes, specify Cuban, Mexicen, Puerto Rican, atc.)
 I
 ▼ YES 2 □ NO Specify: 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 X Married IF YES, GIVE WAR OR DATES BΥ 3 Wildowed 4 Divorced Salvadoran Hispanic COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Architectural Engineer Construction 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Antonio Garcia Silvia Garcia BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Efrain B. Caballero 531 Beetz Road, Mt. Airy, Maryland 21771 20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other place) July 20a. METNOD OF DISPOSITION 20c. LOCATION - City or Town, State DATE 1 St Burlai 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 24, 1995 San Vicente Santa Domingo Cemetery 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc.
7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00198 OL 23. PART I. Enter the diseasee, Dr complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory erreet, Approximate shock, or heart failure. Liet only one cause on each line Interval Between IMMEDIATE CAUSE (Finel Onset and Death DUE TO (OR AS A CONSEQUENCE OF): disease or condition_ Multiple resulting in deeth)

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i.

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN

24a. WAS AN AUTOPSY PERFORMED? 1 PYES 2 □ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

JULY 17,1995

5. WAS CASE REFERRED TO MEDICAL	28. PLACE OF DEATN (Check only one)										
EXAMINER? 1 TYPES 2 NO	HOSPITAL: 1 Inputient 2V ER/Outputient 3 DOA	OTHER: 4 □ Nursing Nome 5 □ Residence	8 Other (Specify)								
27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation		ME OF 28c. INJURY AT WORK? 1 YES 2 NO	Subject fell off Lorda								
3 Suicide 6 Could not be detarmined	28a. PLACE OF INJURY — At home, ferm, building, etc. (Specify)	street, factory, office	281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 531 Beets St Bullimene								

1 _ CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as (Check only one)

2 TymeDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

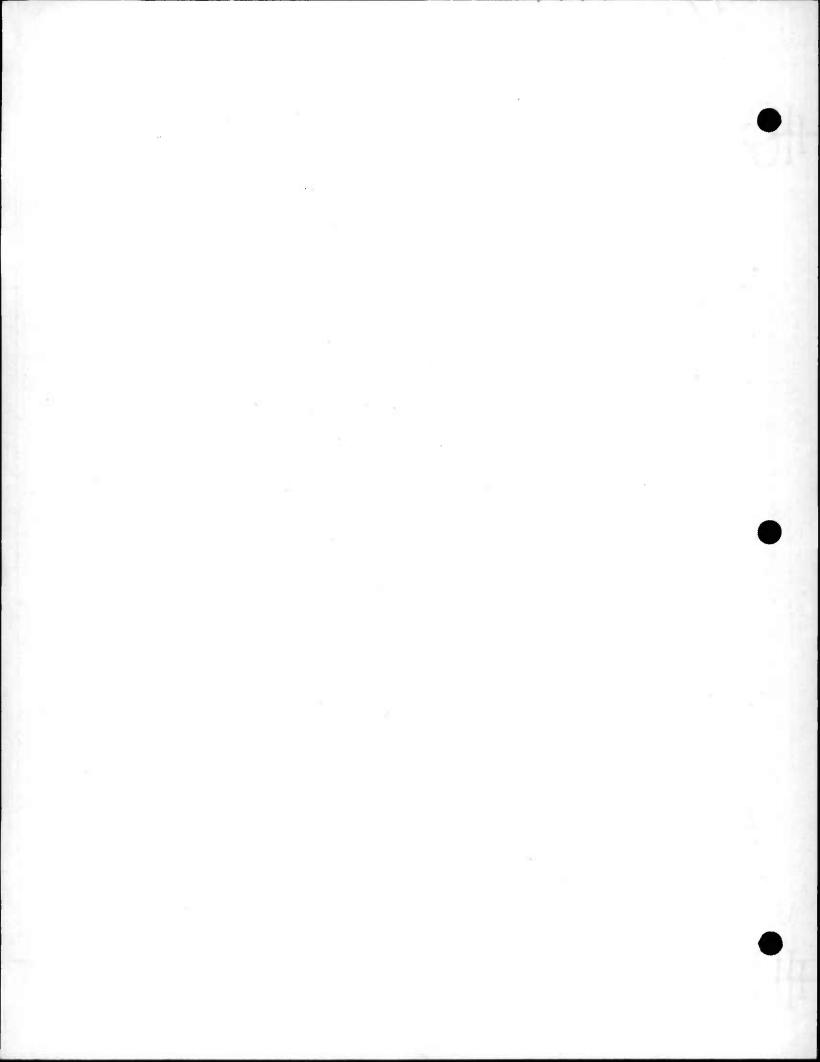
111 Penn Street, Baltimore, Maryland 21201

29c. LICENSE NUMBER

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Fouler 32 REGISTBAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) Julia Davelson Revolate 20 1995

DIVISION OF VITAL RECORDS, P.O. BOX 68760



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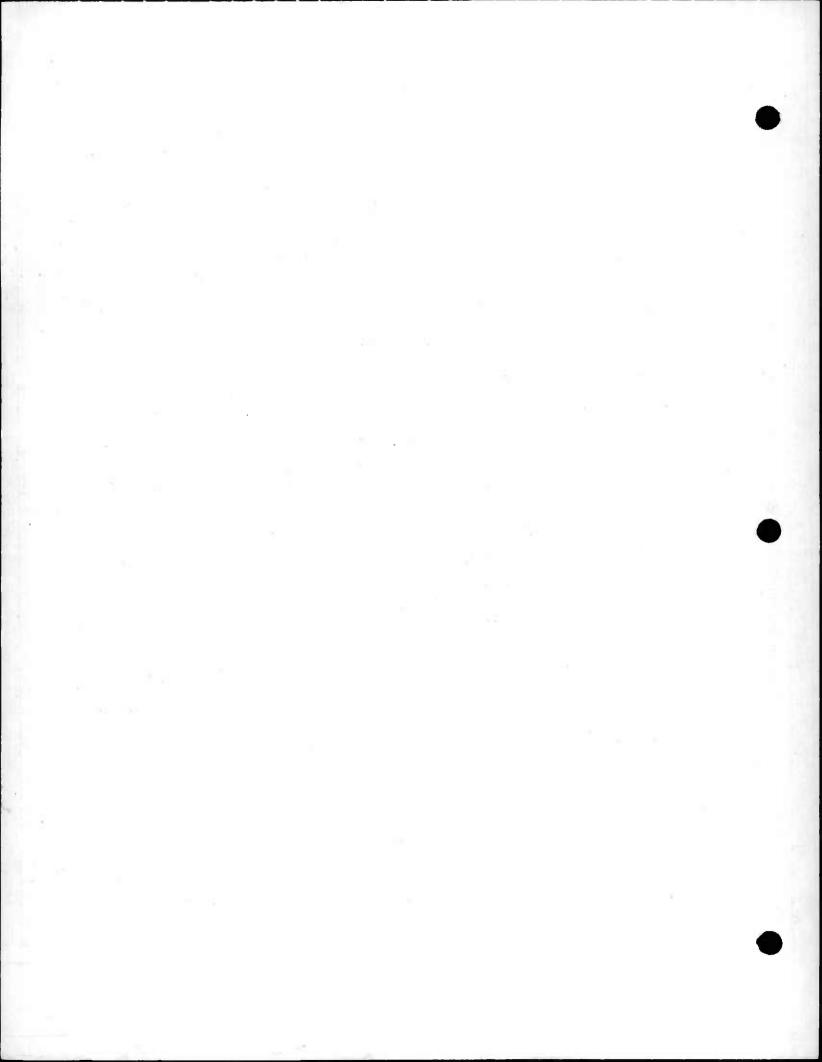
DIVISION OF VITAL RECORDS, P.O. BOX 68760 S BALTIMORE, MARYLAND 21215-0020

it. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and hours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
RAR	CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE OF STATE OF	MARYLA	ND / DEPA	RTMENT	OF H	EALTH AND DEATH	MENT	AL HYGIEN	E					
	1. DECEDENT'S NAME (First, Middle, Last)	-		2. DATE OF DEATH							3. TIME OF DE	ATH		
	James Hinton	Gra	ves, J	r.			Ju	Ly 13,	12:25	Ам				
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (II	n yrs. lest birthdey) IF UNDER		IF UNDER 24 HRS.	7. DAT	E OF BIRTH	8. BIRTHPLACE (State or Fi			Foreign		
	167-12-8576 1 ⋅ M 2 □	9	3 YRS.	MONTHS	DAYS	HOURS MIN.		ch 16,1						
œ	9a. FACILITY NAME (If not institution, give street and number)					R LOCATION OF D	DEATH		9c. COU	NTY OF D	EATH			
DIRECTOR	Washington Adventist Ho	spital		Tal	koma	Park			Mot	ntgo	mery			
EC	10a. STATE 10b. COUNTY		10c. C	ITY, TOWN C	R LOCATI	ION					10d. INSIDE CI	TY		
Ö	Maryland Montgomery	I	Kensir	igtoi	n			LIMITS:						
IAL	10e. STREET AND NUMBER					ZIP CODE			VHAT COUNTRY					
FUNERAL	11402 Soward Drive				20	0895-142	23		USA					
E	11. MARITAL STATUS 1 Never Married 2 Married FORCES?	1 X YES	2 NO	13.	WAS DECE	ENDENT OF HISPA	NIC ORIG	IN? (Specify Year Ricen, etc.)	or No-	14. RACE Black	- American In	dlen,		
BY	3 ⊠ Widowed 4 □ Divorced IF YES, GIV	1962	TES	'	YES	2 NO Specif					White			
ED	15. DECEOENT'S EDUCATION		16a. DECEDENT	'S USUAL O	CCUPATIO	N .	16	Sb. KIND OF BUS	INESS/IND	USTRY	WILLE			
Ē	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or	5+)	(Give kind o	of work done of use retired.)	during mos	t of working								
MP	12		Owner/	Opera	tor			Shipbu	ildir	ıg				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NA	AME (First	Middle, Malden	Sumame)					
BE	James Hinton Graves, Sr.							endelt			7			
2	19a. INFORMANT'S NAME (Type/Print) Barbara Glaser					nd Number or Rural								
	20a. METHOD OF DISPOSITION	1				Drive,					0895			
	1 Serial 2 Cremation 3 Removal from State	20b. I	PLACE AND DAT	e of DISPOS other place)	ITION (Nan	Teof 7/31 L Cemete	195	TE 20c. LO	CATION —					
- 4	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		TIUSCOL		_			Arı	ingto	gton, VA				
Ŋ	Francis J. Collins Funeral Home, Inc.													
	Janaaria S. C	ans	rzun	50	0 Ur	iversit	y B1	vd.W.	Sil.S	pr.M	D 2090	1		
	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feliure. List only one cause on each line. Approximate interval Between													
	iMMEDIATE CAUSE (Fine) disease or condition HVDAY	EMT A	DECDID	TOD37	TAICI	IDDICTON	1037				Onset a	nd Death		
	resulting in death)		RESPIRATORY INSUFFICIENCY											
_	_ Pneumo		CONSCOUENCE	OF):										
CERTIFICATION	Sequentielly list conditions, if any, leeding to immediate													
8	if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury	3												
E	that Initiated events		O (OR AS A CONSEQUENCE OF):											
ER	resulting in death) LAST Chron.	ic bra	ain syndrome											
	PART II. Other aignificent conditions contributing	to death bu	t not resulting	in the un	derlying	ceuse given in	Part i.	24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY	FINDINGS		
PHYSICIAN: MEDICAL	Chronic aspiration					V. 13 (15 / 15 / 15 / 15 / 15 / 15 / 15 / 15		PERFOR			AVAILABLE PRIO	R TO		
AED					T U YES						OF DEATH?	110		
ž	DID TOBACCO USE CONTRIBUTE TO C	AUSE OF	DEATH Y	ES 🗆 N	10 🗆	UNCERTAIL	ΝП				1 _ YES 2 _	NO		
SIA	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DE				- Land							
l Sic	EXAMINER? XX 1 YES 2 NO HOSPITAL: 1 X Inputient	ER/Outpet	tlent 3 🗆 DOA	4 Num		5 Residence	6 🗆 Oth	er (Specify)						
E	27. MANNER OF DEATH 28a. DATE (Month	OF INJURY Day, Year)	28b. Ti	ME OF	28c. INJU WOR	RY AT	28d. DE	SCRIBE HOW IN	JURY OCC	URED				
Æ	1 Natural 5 Pending 2 Accident Investigation			M	1 🗌 YI	ES 2 NO						1		
	3 Suicide 8 Could not be 28a. PLACE buildir 4 Homicide determined	OF INJURY - g, etc. (Specify	- At home, farm	street, facto	ory, office		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLETED						-								
P P	29e. CERTIFIER (Check only one)													
Ö	2 MEDICAL EXAMINER: On the beels o	axamination	and/or investigat	lon, in my o	pinion, de	ath occured at the	time, det	a and place, and	dua to the	e cause(a)	and manner as	stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIER		0,14	266.4	. ,	29c. LICENSE NUI			29d. DATE	SIGNED	(Month, Day, Year)		
2		ue		SICIA	N	D23177			Ju	11y 1	13, 199	5		
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CO. Mario O. Belledonne, M.I				o= - 1	T	205	D = -1	:17	M				
				ressi	onal	Lane #	205	KOCKV	ттте,	MD				
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE JUL 18 1995														



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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Julia Davelson Randall

1995

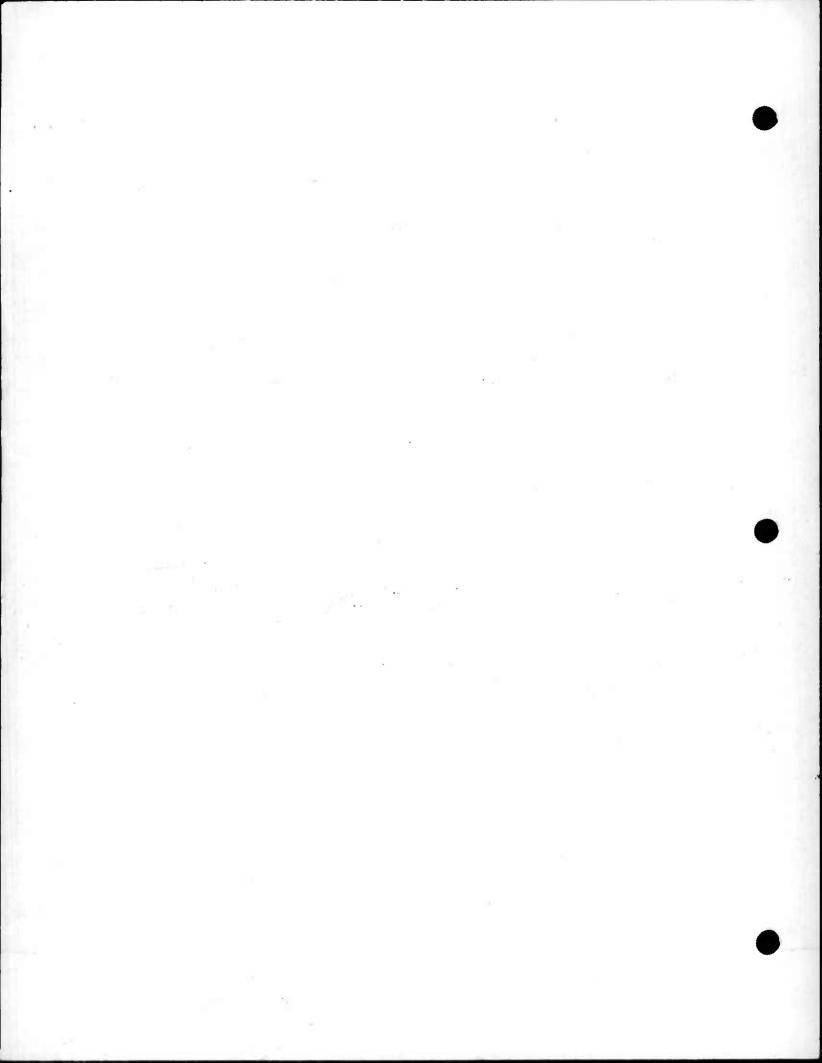
CHAU ELAEN

31. DATE FILED (Month, Day, Year)

95 23352 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 KATHERINE **GUERRA** JULY 2:50p.m. M 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 1 M 2 X F DAYS HOURS 071-07-3387 86 YRS. March 17, New York 1909 9a. FACILITY NAME (If not institution, give street and number 96. CITY, TOWN OR LOCATION OF DEATH LANHAM SEABROOK 9c. COUNTY OF DEATH COMMUNITY DOCTORS HOSPITAL DIRECTOR PRINCE GEORGE'S CO RESIDENCE OF DECEDENT 10a. STATE 10h. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Berwyn Heights 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 18g. CITIZEN OF WHAT COUNTRY? 6000 Berwyn Road 20740 United States 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If was specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 14. RACE — American Indian, If yes, specify Cuban, Mexican, Puerto Ri
1 YES 2 X NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES B 3

Widowed 4 ☐ Divorced White ETED. 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 8 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Mark Summo Katherine Traficonti BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary Ann Zito (Daughter) Same as #10 Pe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must Olivet Cemetery 7/19 Kenmore, NY examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD M00827 20910 medicai 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as Approximete ahock, or heart failure. Liet only one ceuse on each line. intervai Between IMMEDIATE CAUSE (Finel Onset end Death the disease or condition resulting in deeth) event. traumatic CERTIFICATION Sequentielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING W84; CAUSE (Disease or injury DUE TO (OR AS A CONSEQUE that initiated events resulting in deeth) LAST PART II. Other aignificent conditions contributing to deeth but not resulting in the underlying years given in Part I. 24s. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 1 HO mer 1 YES 2 XNO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER:
4 \subseteq Nursing Home 5 \subseteq Residence 8 \subseteq Other (Specify) 1 | YES 2 | NO patient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH 28b. TIME OF 28a. DATE OF INJURY 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, Month, Day, Year, 1 Natural 1 YES 2 NO BY 2 Accident Investigation 3 Suicide 28e. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town. State) 28 18 8 Could not be COMPLETED 4 Homicide determined 29a. CERTIFIER 1 DERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIE BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D13335

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the month of the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MOUTH DAY VEAR 3. TIME OF DEATH										3. TIME OF DEATH			
	G	rover	E. Green	монти Лу					MONTH DAY YEAR			10:48 P.MM		
	4. SOCIAL SECURITY NUMBER 5. SEX			6. AGE (In yrs. la	st birthday)					7 DATE OF BIRTH & BIRTHRI ACE /S			PLACE (State or Foreign	
	214-07-534	8	1 M 2 F	84	YRS.	MONTHS	DAYS	HOURS	MIN.	Oct 1	0,191	10	Country	yland
	9a. FACILITY NAME (If not in		street and number)			9b. CIT	96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH						ATH	
8	12821 Jeal	ow. N.W.			Mt.	Sava	age			A	llega	anv		
5	RESIDENCE OF DEC							-						
🖺	T TOWN ON COCKION										10d. INSIDE CITY			
												1 X YES 2 NO		
HA	106. STREET AND NUMBER 107. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? 21545 U.S.A.													
ᄬ														
											White, etc.			
	> IF YES, GIVE WAR OR DATES 1 ☐ YES 2 🖫 NO Specify: Specify:										White			
COMPLETED	15. DEC	EDENT'S EDU	ICATION completed)	18a. D	ECEDENT'S Give kind of	USUAL O	CCUPATIO	ON not of worki	200	18b. KIND	OF BUSINE	SS/INDU	ISTRY	
9	Elementary/Secondary (I		College (1-4 or 5	100	Do NOT us	se retired.)	during me	IST OF WOTEN	ng					
MP	5				Spi	nner				Tex	tile			
8	17. FATHER'S NAME (First, M									ME (First, Middle, i		name)		
B	Harry Gr									la Lyne				
<u>و</u>	19a. INFORMANT'S NAME (1	,,								Route Number, City				
	Thelma Gre								v, N					MD 21545
	20a METHOD OF DISPOSIT 1 Burlet 2 Cremetic	on 3 - Rem	oval from State	20b. PLACE cemetary, co	AND DATE	OF DISPOS ther place,	SITION	ame of			Oc. LOCATI			
	4 Donation 5 Other 21. SIGNATURE OF FUNERA		CENSEE	_ 50.	ratri	CKS	Ceme	tery	- OF F4	01/22 CILITY 57	MU	Sava	ge,	Maryland
	▶ () ohn		11 /			- 1								
	#		Farm											id. 21532
	23. PART Enter tha d	iseasea, or	complications the	at caused the d	aath. Do i	not entai	tha mo	de of dy	ing, suc	h as cardiac or	respirato	ory arre	st,	Approximate
	IMMEDIATE CAUSE (Fir		nn A	-1-1			A	4						intarval Batween Onsat and Death
	disease or condition resulting in death)	\rightarrow	. Mela	statee	1	200	lal	ee	Car	uces				Bulary
	,		DUE TO	OR AS A CONSE	OUENCE O	F):								0
N	Sequentially list condit	lona.	b											
M M	if any, leading to imme cause. Enter UNDERLY	diate	DUE TO	OR AS A CONSE	OUENCE O	F):								
CERTIFICATION	CAUSE (Disease or inju		c. DUE TO	OR AS A CONSE	OUENCE O	D.								
E	that initiated events resulting in death) LAS	т		(on no n oonse	.0021102 01	. ,.								
S			d											
AL.	PART ii. Other aignifica	ent condition	na contributing to	death but not	raaulting	in the u	nderlyin	g cause	givan in	Part i. 24a. V	AS AN AUT			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDICAL											YES 2			COMPLETION DF CAUSE OF DEATH?
ME	=======================================		-											1 YES 2 NO
ž	DID TOBACCO		CONTRIBUTE	TO CAU	SE OF	DEAT	H Y	ES 🛛	NO					
PHYSICIAN:	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:			OTHE		ACE OF D	EATH (Che	eck only one)				
YSI	1 TES 2 NO		1 Inpatient 2	☐ ER/Outpatient	3 🗆 DOA	4 Nu	H: Bing Hon	6 5 R	sidence	6 - Other (Speci	fy)			
F	27. MANNER OF DEATH	Pending	28a. DATE Of (Month, L		28b. TIM	URY	28c. INJ WC	URY AT		28d. DESCRIBE	HOW INJUI	RY OCCU	JRED	
BY	2 Accident	Investigation				М		YES 2	NO					
	3 Suicide 8	Could not be determined	26a. PLACE C building.	OF INJURY — At h., atc. (Specify)	oma, ferm,	streat, fac	tory, offic			281. LOCATION (City or Town		Number o	r Rural Ro	oute Number,
COMPLETED			ICIAN: To the best of											
ő	2 MED	ICAL EXAMINE	R: On the beele of a	examination and/or	Investigation	in, In my	opinion, o	leath occu	red at the	time, data and pl	ace, and du	ue to the	ceuse(a)	end manner as stated.
ш	296. SIGNATURE AND TITLE	OF CENTIFIE	P // /	\	-	D	4.		ENSE NUN	IBER	29	d. DATE		(Month, Day, Year)
то в	Wan	n	1	10	ugg	0	3	م	11	244			7. 9	20,95
-	30. NAME AND ADDRESS OF	F PERSON WH	O COMPLETED CAU	2	11	Print)								
			iggle. M	D. 912	Set	on D	rive	, Cu	mber	land. M	d. 21	502		
	31. DATE FILED (Month, Day,	"jqq5	172 AEGISTA	AR'S SIGNATURE	fall				TOPECO O					
	OOUNT	1000	CV .											

. . V 4 BALTIMORE, MARYLAND 21215-0020

DIRECTOR

FUNERAL

BY

COMPLETED

BE

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MEDICAL CERTIFICATION

PHYSICIAN:

BY

4 Homicid 29e. CERTIFIER

6 Could not be

29b. SIGNATURE AND TITLE OF CERTIFIER

30. NAME AND ADDRESS OF PERSO KOLO DRUBE

COMPLETED

BE

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DIVISION OF VITAL RECORDS, P.O. BOX 68760 HOSPITAL DR ATTENDING

noing priysician.	er this certificate has been signed by the artending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit Panes 1, 2 shows		
y he retained by the hospital of att	page 5 should be detached for use		be notified at once.
The receipt of the receipt of the receipt of the receipt of the receipt of the receipt of attending of attending of	ely filled in by the funeral director,	nation, or removal.	MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
min consort of manufactures there	attending physician and complete	th with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ry, or other traumatic event,
יסובתי. וווכ ומנו וכלסווכם חומו חוכ	sertificate has been signed by the	the State Dept. of Health and Mi	, or item 23 shows any inju
Series of Allerance and	UNERAL DIRECTOR: After this co	be filed within 72 hours after death with t	NNT: if item 28 is marked,
-	THE F	be filed w	IMPORT

23354 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** BEG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Marion Pike Grimes July 1995 13. 8:40 p 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 577-16-7578 1 M 2 X F 82 May 30, 1913 Kentucky 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Lorien Nursing Center Columbia Howard RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Howard Clarksville 1 TES 2 T NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 11442 Rowley Road 21029 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 🔀 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuban, Mexican, Puerio Rican, atc.)
1 ☐ YES 2 ☒ NO Specify: t4. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried IF YES, DIVE WAR OR DATES 3 Widowed 4 K Divorced White 15. DECEDENT'S EDUCATION ecify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Sn (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Editor U. S. Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Patrick Pike, Sr. Lucille Elizabeth Payne 194. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, Virginia Whelan 11442 Rowley Road, Clarksville, Maryland 21029 20e. METHOD OF DISPOSITION
1 ₺ Burlal 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Cedar Hill Cemetery 4 Donation 6 Other (Specify) 7/17/95 Suitland, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. lase 4739 Baltimore Ave., Hyattsville, MD 20781 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such ea cerdisc or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. Approximate Interval Between **IMMEDIATE CAUSE (Final Onset and Dasth** disease or condition_ variue resulting in death) Sequentielly list conditions, DUE TO OR AS A CONSEQUENCE OF if any, laading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated avents resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) NIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26c. INJURY AT WORK7 26e. DATE OF INJURY 26b. TIME OF 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO Investigation 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 261, LOCATION (Street and Number or Rural Route Number, City or Town, State)

To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(e) end menner se stated.

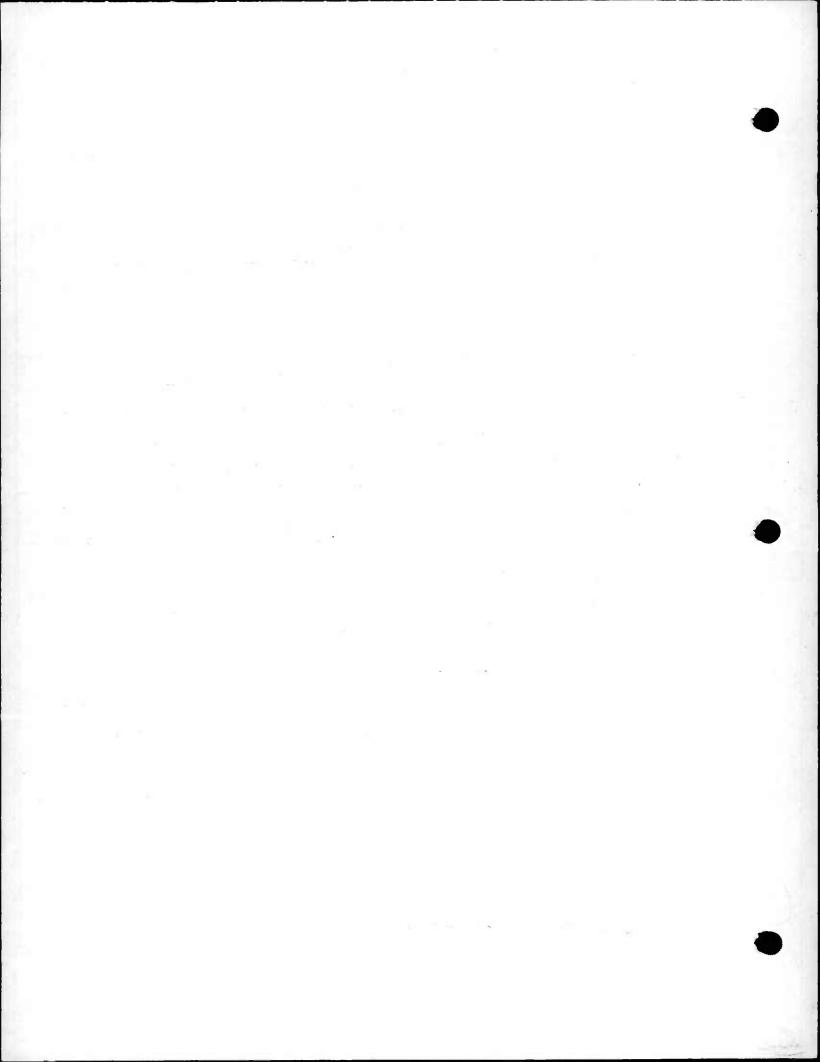
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end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) end manner ee stated.

29c. LICENSE NUMBER

-25

29d. DATE SIGNED (Month, Day, Year)



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	_	REGISTRAR			CERTIFIC	ATE O	F DEATH		REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF			3. TIME OF DEATH
		ONIAD	C60018	hil				4 SILL	13	YEAR	1130/000
		4. SOCIAL SECURITY NUMBER		B. AGE (In yrs.	land blotheland	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF			14-7111) "
			1. M 2 F			ONTHS DAYS		(Month, I	Day, Year)	Cou	THPLACE (State or Foreign intry)
꾶		578-64-2382	4.5		46 YRS.		1000	Oct.	22,194	48 Was	hington, D.C.
3 should		9e. FACILITY NAME (If not institution, give str	eet end number)		9	b. CITY, TOWN	OR LOCATION OF D			9c. COUNTY OF	
ဗိ	E I	Golden Oaks Nurs	ing Home		1	Lauı	e o 1			D !	0
, 2,	DIRECTOR	RESIDENCE OF DECEDENT	Ing nome	_		Laui	ет			Prince	Georges
Se	Ĕ I	10e. STATE 10b. COUNTY			10c. CITY, T	OWN OR LOC	ATION				10d, tHSIDE CITY
Z.	는 I				77-	1- 1	D 0				LIMITS?
i i		10e. STREET AND NUMBER			was		on, D.C.				1 X YES 2 NO
020 physician. burial-transit permit. Pages	FUNERAL	The state of the s				1	IOF. ZIP CODE		11	10g. CITtZEN OF	WHAT COUNTRY?
n. ansi	<u> </u>	4717 Illinois Av	e.,N.W.				20011			U.S	. A .
o Sicial	5		12. WAS OECEDENT	EVER IN U.S.	ARMED	13. WAS DI	ECENDENT OF HISPAN	IIC ORIGIN?	Specity Yea or	No.— 14. RA	CE — American Indian
Phy bury		1 Never Merried 2 Merried	FORCES? 1 V	P OR DATES	NO	Il yes,	spectfy Cuban, Mexico	n, Puerlo Ric	an, atc.)	Bla	ick, White, etc.
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YLAND 21215-00 by the hospital or attending be detached for use as the at once.	Ω.	15. DECEDENT'S EDUC	ATION		DECEDENT'S US	UAL OCCUPAT	ION	I see v	NO OF BUOM	ESS/INDUSTRY	
12 use at	E	(Specify only highest grade of	ompleted)		(Give kind of work life. Do NOT use n	done during r	nost of working	100. K	IND OF BUSIN	ESS/INDUSTRY	
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ds of per set	ž	12			Cust	odian			Priva	ate Ind	ustrv
AN the hox detach	COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA		dle, Malden Su		
3 E E		Uni	known				Levoli	la Hai	zlip		
De de de de de de de de de de de de de de	B	19a. INFORMANT'S NAME (Type/Print)	- .		195 MAILING AC	ODESS (Charles	and Mumber or Dunct	Davida Maraka	00		
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burlal-tran	2			- 1			end Number or Rural I				
2 8 9		Levolia Goolsby	7		4717 I	llinoi	s Ave. N	I. Was	hingto	on.D.C.	.20011
2 Pag 22		20e. METHOD OF DISPOSITION	and down Charte		EANDDATEOF	DISPOSITION /		DATE		TION — City or	
BALTIMORE, after death. Page 6 may be by the funeral director, page moval.		1-Buriel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	Aut from State	O1121	cremetory or other	place)	1 Cem. 7/	17/05	0,,,,,,,,	+400	77
Z 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17	21. SIGNATURE OF FUNERAL SERVICE LIGH		1 Qua	ILICO IV	22. NAME	AND ADDRESS OF FA			itico.	
ALTIN death, Pag e funeral di ii,	1	2011	1	/,				FI		Funera	
SA de fu		W. A.	LA FOR	er	2	389	Rhode Isl	and A	v.,NW,	Washin	gton, D.C.
nours after d in by th		23. PART I. Enter the diseases, or co	molications that	caused the	deeth Do not						
AND 8 = 2 8		shock, of heart fallure. L	ist only one cause	e on eech i	ne.	onter the h	oue or dying, auc	II as Carula	c or respirat	bry errest,	Approximate Interval Between
		IMMEDIATE CAUSE (Final		0							Onset and Death
		disease or condition resulting in death)		(NE	ひつしつ	IVA					1 mays
1760 ted within completely iai, cremat		a.	DUE TO (C	AS A CON	SEQUENCE OF:						201-
C68760, executed with and complete o burial, crement matic evening.	_	_		1 0	7/5		- 51				
68 mecut and c buri	ó	Sequentielly list conditions, b.	DHE 70 (0	200	SEQUENCE OF):	C/000	Carc a	1 1024			70215
De es sian a sum	E	if any, leading to immediate	DOE 10 (0								-4
	CERTIFICATION	CAUSE (Disease or Injury			3000	~	17575	BN	000	८५३३	70225
DS, P.O. B(the death certificate the attending physic of Mental Hygiene pri	쁜	that initiated events	DUE TO (O	R AS A CON	SEQUENCE OF):						
, P.O. eath certific attending parter Hygien y, or othe	E	resulting in deeth) LAST									
OS, Poe death the atter Mental Mental	2										
CORDS, res that the dea igned by the att eath and Menta		PART II. Other significent conditions	contributing to d	eath but no	t resulting in t	he underlyl	ng cause given in	Part I. 24	Ia. WAS AN AU		Ib. WERE AUTOPSY FINDINGS
CORE ries that the signed by a seath and we any in	EDICAL	JEIZUE	ರ						PERFORME		AVAILABLE PRIOR TO COMPLETION OF CAUSE
Signed Health Ws any	8							一 '	YES 2	NO	OF DEATH?
	Ξ							_			1 TYES 2 NO
AL RE law require law require law seen a Dept. of H	z	DID TOBACCO USE CONTRI	BUTE TO CAU	SE OF DI	ATH YES,	I ON [UNCERTAIN	1 🗆		2	
VITAL AN: The law tificate has e State Dep	PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL			ACE OF DEATH (
F VITA SICIAN: The certificate h the State (8	4 🖂 2000 - 4 🖂 440	HOSPITAL:	R/Outpatlant		THER:					
rhe the	<u></u>	27. MANNER OF DEATH	280. DATE OF IN		28b. TIME O		me 5 Residence				
NG PHYS frer this cath with	ā	1 Natural 5 Pending	(Month, Day,		INJURY		IJURY AT ORK?	28d. DESCR	IBE HOW INJU	JRY OCCURED	
ONG POING P	E I	2 Accident Investigation				M 1 🗆	YES 2 NO				
O S S S S		3 Suicide 6 Could not be	28e. PLACE OF building, et	INJURY - At	home, farm, atree	et, factory, off	Ice	281. LOCATI	ON (Street and	Number or Rura	Route Number,
DIVISION OF VITA OR ATTENDING PHYSICIAN: The OIRECTOR: After this certificate ha hours after death with the State D Item 28 is marked, or item:		4 Homicide determined		a (opodity)				City or	lown, State)		
DIV OREC	91	29e. CERTIFIER									
A Z P P P P P P P P P P P P P P P P P P	를	(Check only									
HOSPITAL FUNERAL Within 72 I	COMPLETED	one) 2 MEDICAL EXAMINER:	On the basis of exam	mination end/	or Investigation, is	n my opinion,	death occured at the	time, date en	d place, end d	ue to the ceuse	(s) and menner ea stated.
	- 11	29b. SIGNATURE AND TITLE OF COMPANIE	-				29c. LICENSE NUM	-			
THE HOSPI THE FUNER filed within	8	10%	7				DS2A		25	9d. DATE SIGNE	D (Month, Day, Yeer)
P P B M	2	177	1		11		200 4			7/1	5/95
(3)	- 1	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	OF DEATH (I	TEM 27) (Type, Prii	nt)				,	
		16.0	717661-	V, m	0		LAURO	2 0	70	207	08
				_				,			
		31. DATE FILED (Month, Day, Year) JUL 21 1995	32. FERIŞTRAR	Later	artale						
		302 32 200	10								
											DUMM 16 Day 1/80

1 - STATE REGISTRAR	STATE OF MAR	YLAND / Ce	DEPAF RTIF	RTMEN ICATI	TOFH EOF	EALTH DEAT	AND I	MENTAL HYGIENI REG. NO.	E		
1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATN			3. TIME OF DEATH
ANNA REBEC		NLEE						July 5 1995 9:55 A			
4. SOCIAL SECURITY NUMBER 5	MONTHS	DAYS	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		Country	PLACE (State or Foreign			
578-22-8741 1		13	YRS.			-		NOV. 6, 19			ington, DC
	t and number)				r, TOWN O			ATN		INTY OF DE	
4704 Cooper Lane				Нуа	ttsv	TITE			Pri	nce (George's
10c. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Drinco Goorgo's Hypathevillo											10d, INSIDE CITY LIMITS?
Maryland Prince George's Hyattsville 1 □ YES 2 💢 NO											
4704 Cooper Lane 20784 United States											
	2. WAS DECEDENT EVE	R IN U.S. ARI	MED	13.	WAS DECI			IIC ORIGIN? (Specify Yes			- American Indian,
1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 Y	ES 2 N R DATES	0		If yes, spe 1 YES	city Cubs	n, Mexica	n, Puerto Rican, etc.)		Black, Specifi	, White, etc.
15. DECEDENT'S EDUCAT					CCUPATIO			16b. KIND OF BUS	INESS/INI	DUSTRY	White
(Specify only highest grade cor Elementary/Secondary (0-12)	mpleted) College (1-4 or 5 +)	(Gh	ve kind of Do NOT u	work done se retired.)	during mos	t of workin	19				
	1	Car	togr	aphi	с Те	chni	cian	U.S. Go	vern	ment	
17. FATHER'S NAME (First, Middle, Last)								ME (First, Middle, Malden S	Surname)		
John C. Hammond, St.	<u>^.</u>	400			2 10			Young			
Deborah Swingle								ttsville,			20784
20e. METNOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Remova		20b. PLACE A	natory or o	ther nlace i						City or Tow	
4 Donation 5 Other (Specify)		Fort	Linc	oln	Ceme	tery	7/	7/95 Bre	ntwo	od, N	Maryland
STATE OF COLUMN STATE OF LIGHT	He /			F	name an	Linc	oln	Funeral Ho	me,	Inc.	
22 PART Enter the discourse or con	Marco	- 140 - 1		3	401	Blad	ensb	urg Rd., B	rent	wood,	, MD 20722
23. PART I. Enter the diseases, or com shock, or heart failure. Lie	t only one cause o	sed the das n aach iina.	ath. Do i	not anter	the mod	le of dyl	ng, aucl	n as cardiac or reapir	atory ar	rest,	Approximata Interval Between
IMMEDIATE CAUSE (Final disease or condition resulting in death)	Termi	nocl	C	an (zin	Sm	9 (OF Pani	cre	a Se	Sch+93
	DUE TO (OR A	S A CONSEQ	UENCE O	F):			. /	DF Pani		. 0.5	777
Sequentially list conditions, b	DUE TO (OR A	14CT	UENCE O	FI-	20	M	201	nce			May 95
If any, leading to Immediate cause, Enter UNDERLYING				,,							
CAUSE (Disease or Injury that initiated events	DUE TO (OR A	S A CONSEO	UENCE O	F):							
resulting in death) LAST											
PART II. Other significant conditions c	ontributing to deat	h but not re	auiting	In the un	darlying	cause g	lven in	Part I. 24s. WAS AN /	WTOPSY	24b.	WERE AUTOPSY FINDINGS
Chronic Obs	Hucti	Vel	ulr	non	any	Di	Sec	PERFORM			AVAILABLE PRIOR TO COMPLETION OF CAUSE
Congestive	Heart	Fa	ile	100	, ,			- T'''''	NO.		OF DEATN?
DID TOBACCO USE CONTRIB	UTE TO CAUSE	OF DEAT	TH YE	S 🗆 Ì	NO M	UNC	ERTAIN	10			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	28. PLACE	OF DEAT	OTHER	-	,					
	☐ Inpatient 2 ☐ ER/C			4 🗌 Nun	sing Home	\rightarrow	sidence	8 Other (Specify)			
1 Natural 5 Pending	(Month, Day, Yes		28b. TIM	URY M	28c. INJU WOR		140	28d. DESCRIBE NOW IN	JURY OC	CURED	
2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJU	JRY — At hon	ne, farm, s	street, fact		2 2	NO	281. LOCATION (Street or	nd Number	or Rural Ro	usta Number
4 Nomicide determined	building, atc. (5	Specify)						City or Town, State)	ia riginioni	or ribrer rib	ate Number,
29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner es stated.											
2 MEDICAL EXAMINER: C	in the baels of examina	ition end/or in	rvestigatio	n, In my o	pinion, de	ath occur	ed at the	time, date end place, end	due to th	ne ceuse(e)	end menner ee stated.
296. STONATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)											
30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)											
RAKESH A ROPA, MD14300GALLANTFOXEN, 130WIE, MD20715											
31. DATE FILED (Month, Day, Year) JUI 17 1995	31. DATE FILED (Month, Day, Year) 32. REGISTRARYS SIGNATURE O										

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

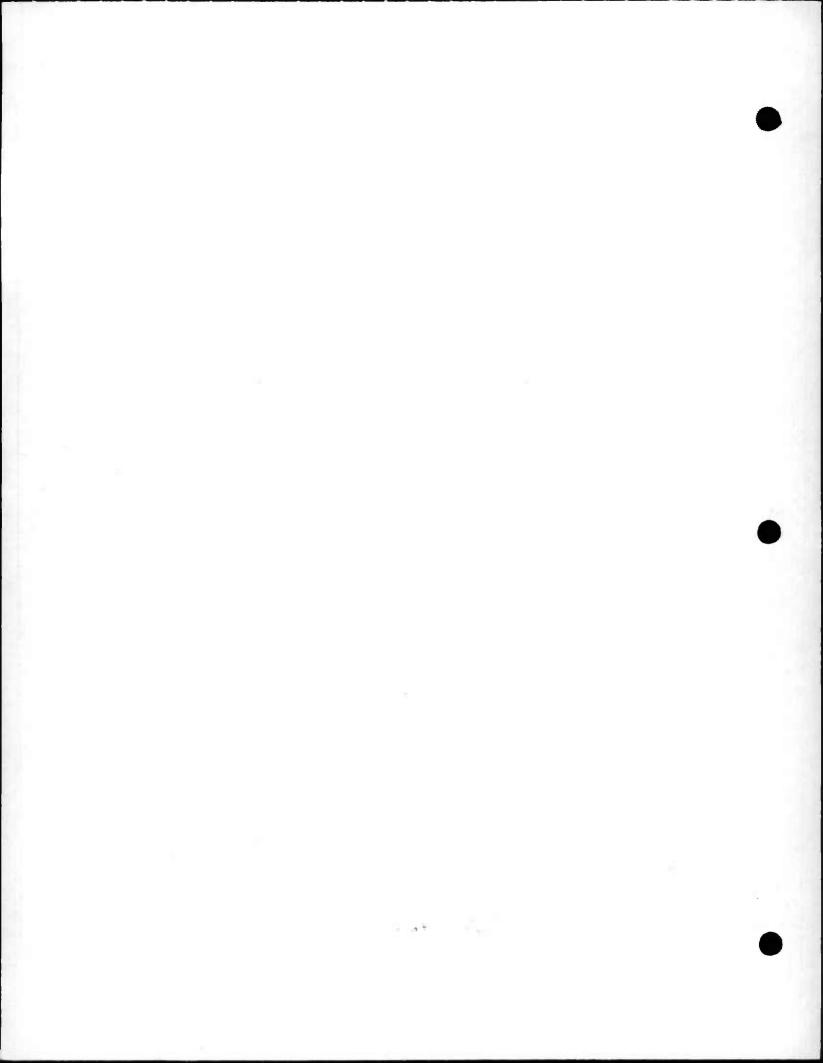
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Day, Year)

JUL 17

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR



Pages 1, 2, for use as the burial-transit permit. hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-tran filled in by the

6

BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled	i filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN YEAR CORDELIA SHARON GARCIA July 1995 3:43 Рм 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs, lest birthday) 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAVE HOURS 495-26-1376 1 M 2 X F 68 6, May Iowa 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Prince George's Hospital DIRECTOR Cheverly Prince George's RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George's Hollywood 1 X YES 2 | NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? P.O. Box 123 20636 U.S.A. 11 MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 8F YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuben, Mexican, Puerto Rican, etc.)

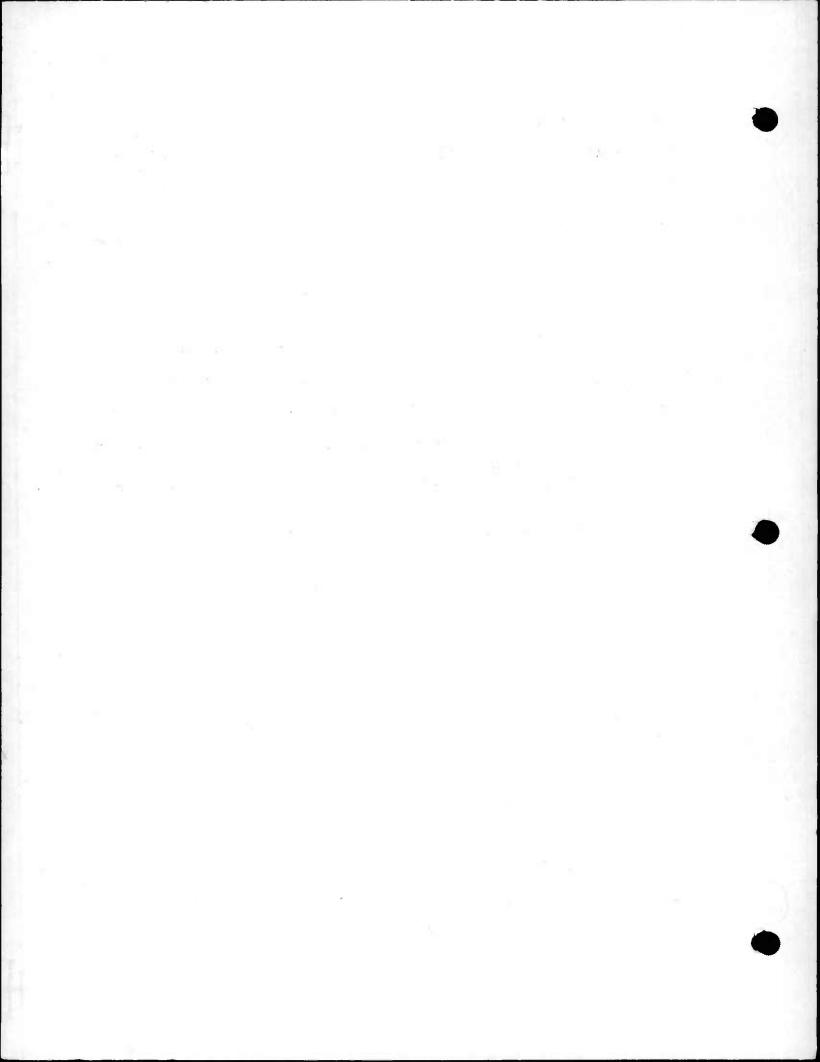
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried BY 3 🕅 Widowed 4 🔲 Divorced White 18e. DECEOENT'S USUAL OCCUPATION

Advance during most of working COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complet 16b. KINO OF BUSINESS/INOUSTRY (Give kind of work done life, Do NOT use retired.) nentary/Secondary (0-12) College (1-4 or 5+) 12 Licensed Practical Nurse Medical 17. FATNER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) To. Phillip Sheridan Mathis BE Alta Gladys Hamblin notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Christine Carlino 991 Cladbourne, Millbrae, California 94030 90 20a METHOD OF DISPOSITION
1 ☑ Burlet 2 ☐ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State must Pleasant Valley Cemetery 7/15/95 4 Donation 5 Other (Specify) Stanley, Kansas traumatic event, the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. Malles 4739 Baltimore Ave., Hyattsville, MD 20781 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter tha mode of dying, auch as cardiec or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximata Intarval Between IMMEDIATE CAUSE (Finel Onset and Death diseese or condition Skin Cancer resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in deeth) LAST 0 PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 TYES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN IN PHYSICIAN: 23 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL:
1 | Inpatient 2 X ER/Outpatient 3 | DOA OTHER: 1 X YES 2 NO 4 Nursing Nome 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED marked, 1 📉 Natural 5 Pending BY 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, term, atreet, tectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, .00 COMPLETED 8 Could not be 4 Nomicide 28 determined Hem 29e. CERTIFIER (Check only one)

1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner se stated. THE HOSPITAL THE FUNERAL I BE filed within 72 h 2 🖔 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner es stated. 296. SHEWATURE AND TITLE OF DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE 3 duque Z D21230 2 ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) Augusto P. Rodriguez, M.D. 5009 Rayburn Court, Camp Springs Maryland 20748

32. REGISTRAR'S SIGNATURE

Jehn Budsock



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	HEGISTRAR		C	ENLIF	ICATE	UF	DEA	l m		REG. NO.			
	1. DECEOENT'S NAME (First, Middle, Last								2. DATE O	F DEATH D	AY	YEAR	3. TIME OF OEATH
		ert H. Hal							July	17,	1995		4:38 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDER 1 Y	_	IF UNDER	24 HRS.	7. DATE O	F BIRTH Day, Year)		8. BIRTH Count	IPLACE (State or Foreign
	496-09-0986	1 🔀 M 2 🗆 F	82	YRS.	months D	Mar. 5, 1913 Count Iow							
	9a. FACILITY NAME (If not institution, give	atreet and number)			9b. CITY, TO	WN OF	R LOCATI	ON OF DE	ATH		9c. COU	NTY OF D	EATH
DIRECTOR	9810 Inglemere D	rive			I	Betl	hesd	a			Mon	Montgomery	
22	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	TV		44 000	CITY, TOWN OR LOCATION								
<u> </u>	Maryland			10c. CIT									10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	Montgomer	У				nesd						1 YES 2X NO
9810 Inglemere Drive 20817 United St 11. MARITAL STATUS 1 Never Married 2 Married 3 Named 4 Divorced 12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 XYES 2 NO If Yes, Specify Cuben, Maxican, Puerto Rican, etc.) 13. Wildowed 4 Divorced 14. RACE — Black, Will Yes, specify Cuben, Maxican, Puerto Rican, etc.) 15. Yes, Specify: Speci										IZEN OF V	WHAT COUNTRY?		
										ted	States		
										E — American Indian, k, White, atc.			
COMPLETED	15. OECEOENT'S EG (Specify only highest grad		16a. OE	CEOENT'S	USUAL OCCU	PATION	N t of workle			KIND OF BUS			
	Elementary/Secondary (0-12)	College (1-4 or 5+	Miles.	. Do NOT us	e retired.)	ng mose	COT WORK	v	Fo	& bo	Drug	Adm	inistration
<u>a</u>	-	5+	Ad	lmini:	strato	r							
g	17. FATHER'S NAME (First, Middle, Last)					П	18. MOTI	IER'S NAI	ME (First, Mi	ddie, Maiden	Surname)		
BE	Frank K.	Hahn		_				Fer	n M.	Hefne	r		
5	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (S	treet an	d Number	or Rural F	Route Numbe	r, City or Town	n, State, Zip	Code)	
F	Irma W. Hahn		9	810	Inglem	ere	e Dr	ive,	Beth	esda.	Mary	vlan	d 20817
	20e. METHOD OF DISPOSITION 1 Burlel 2.A. Cremation 3 Re-										CATION -		
	4 Donation 5 Other (Specify)	mover from State	Montg	ometory or of	her place) y Crem	iato	ily Fiui	n, I	1995 nc.	Bet	hesda	a. Ma	aryland
	21. SIGNATURE OF FUNERAL SERVICE I	ICENSEE			22. NA	WE AND	ADDRES	SS OF FAC	CILITY RO	bert	A. Pı	ımph	rey Funeral
	▶ Xelona	2 Late		202	HOI	le/£	setne	esaa.	-Chev	v Cha	se.	Inc.	. 7557
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resolvetory errest. Approximate												
											Interval Between Onset and Deeth		
	disease or condition resulting in death) Aspiration Pneumonia												
	a. Aspiration Pneumonia 5 days Due TO (OR AS A CONSEQUENCE OF):										5 days		
2	v	Progre	ssive S	upran	nuclea	rF	alse	ev					6 years
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	D	OR AS A CONSE										1 1
§	cause. Enter UNDERLYING												
Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO	OR AS A CONSE	DUENCE OF	7:								
ᇤ	resulting in death) LAST	d.											
2													
EDICAL	PART II. Other algnificent condition			resulting i	n the unde	rlying	ceuse g	ilven in !	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
음	Coronary Arte	ery Diseas	e						_	1 X YES 2			COMPLETION OF CAUSE OF DEATH?
ME													1 TES 2 X NO
	DID TOBACCO USE CON	TRIBUTE TO CAL	USE OF DEA	TH YE	S NC		UNC	ERTAIN	10				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				H (Check only								
SK	1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER: 4 Nursing	Home	5 X R=	sidence	8 Other	(Specify)			
主	27. MANNER OF DEATH	28a. OATE OF	INJURY	28b. TIMI	OF 28	. INJUI	RY AT	T		RIBE HOW II	NJURY OCC	CUREO	
	1 Natural 5 Pending	(Month, De	ly, Year)	INJ		YE	IK? ES 2 [] NO					
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF	INJURY — At ho	me, tarm, s	treet, factory,	office			28f. LOCAT	ION (Street a	nd Number	or Rural F	loute Number,
뒫	4 Homicide detarmined	building, a	itc. (Specify)						City or	Town, State)			,
COMPLETED	29a. CERTIFIER & X												
₽ P	(Check only												
8			amination and/or l	investigation	n, in my opini	on, des	eth occur	ed at the	time, date a	nd place, and	d dun to th	a cause(a) and mennar as stated.
w	29b. SIGNATURE AND THE OF CERTIF	7) ()		/	_		29c. LICE	NSE NUM	BER		29d. DATE	E SIGNED	(Month, Day, Year)
OB	Lee (KITON	ningt	on 1	WO.		D2	1115			Ju	ly 1	8, 1995
5	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUS	E OF DEATH (ITE	M 27) (Type,	Print)			-					
	Lee R. Penningt		5602 S	hield	ls Dri	ve,	Bet	thes	da, M	aryla	nd 2	2081	7
	31. OATE FILED (Month, Day, Year)	33 PEGISTRA	R'SIGNATURE	111									
	JUL 20 1995) July da	WOULDN' INDIVIDU	rally									
		- 194											

20+1

DIVISION OF VITAL RECORDS, P.O. BOX 68760

₽ ₽ a ¥	5 5 3 ₹	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 34 hours after death. Page 6 may be retained by the hospital or attending 10 THE FUNERAL DIRECTOR: After this cartificate has been signed by the attending obysician and completely filted in by the funeral director, page 5 should be detached for use as the be filted within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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BE

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permit. Pages 1, 2, 3 should

burial-transit

Amended # 7, STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF GEATH Margaret E. Henderson July 15 1995 4:30 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 😾 YRS. April 15, Maryland 219-48-3809 79 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH DIRECTOR Frederick 6894 Buckthorn Court Frederick RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Frederick Maryland Frederick 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6894 Buckthorn Court 21701 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 X Merried If yee, specify Cuben, Mexican, Puerto Rican, etc.) ВҰ 1 TYES 2 NO Specify 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or S+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) Raphael Offutt BE Florence Conroy 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Walter Gilbert Henderson 6894 Buckthorn Court, Frederick, Maryland 21701 20b. PLACEANDDATE OF DISPOSITION (Name of cemetery, cremetory or other piece) July 19, 1995
St. Mary's Cemetery 20c. LOCATION — City or Town, State DATE 4 Donation 5 Other (Specify) Rockville, Maryland 22 NAME AND ADDRESS OF FACILITY
ROBert A. Pumphrey Funeral Home/Rockville,
300 West Montgomery Avenue Inc.
Rockville, Marvland 20850-2805 21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00198 0111 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate shock, or heart fellure. List only one ceuee on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disesse or condition Cardiac Arrest 2 minutes reculting in death) DUE TO (OR AS A CONSEQUENCE OF): Systemic Amyloidosis with Cardiomyopathy 2 years CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING Rheumatoid Arthritis 20 years CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reculting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 TO NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 🕅 Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending Investigation м 1 YES 2 NO ВҰ 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED S Could not be

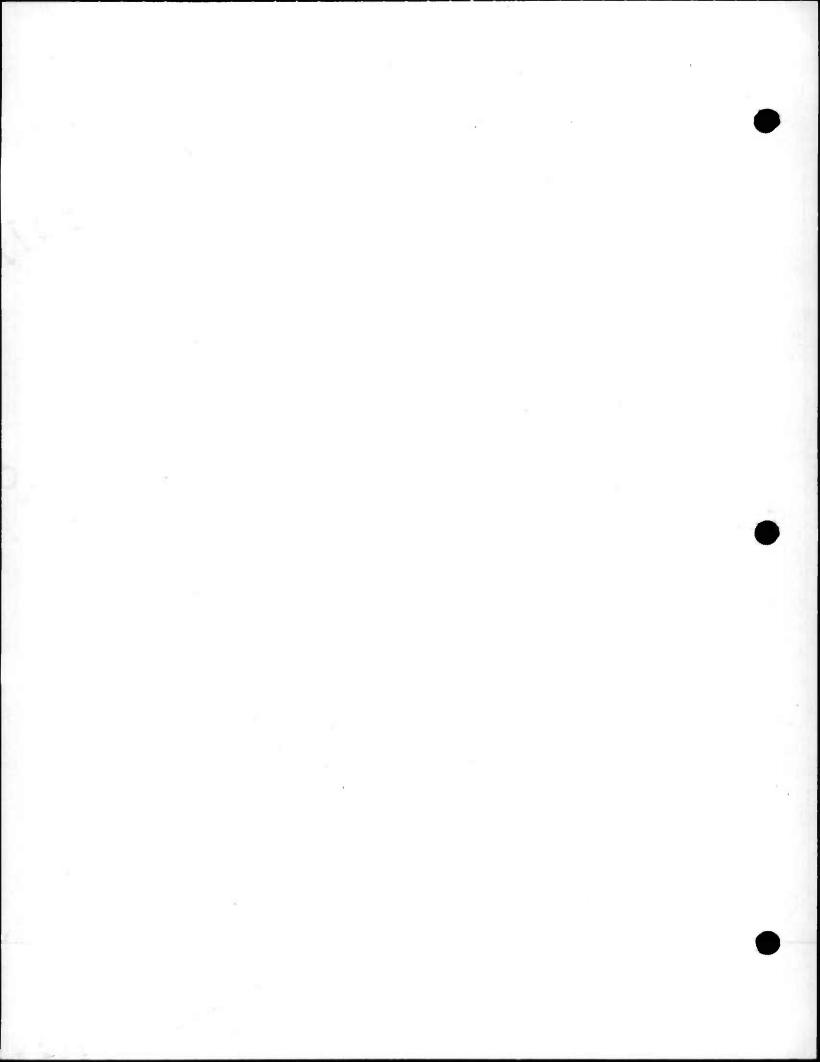
4 Homicide 29e. CERTIFIER (Check only 1 💢 CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end manner as stated. 2 MEDICAL EXAMINER: On the beste of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Jala ann D21340 July 16, 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

Raymond Bass, M.D. 15225 Shady Grove Road, Rockville, Maryland

31. DATE FILED (Month, Dily, Year)

JUL 18 1995 32. REGISTRANG SIGNATURE Pulsa David Surley Revolate



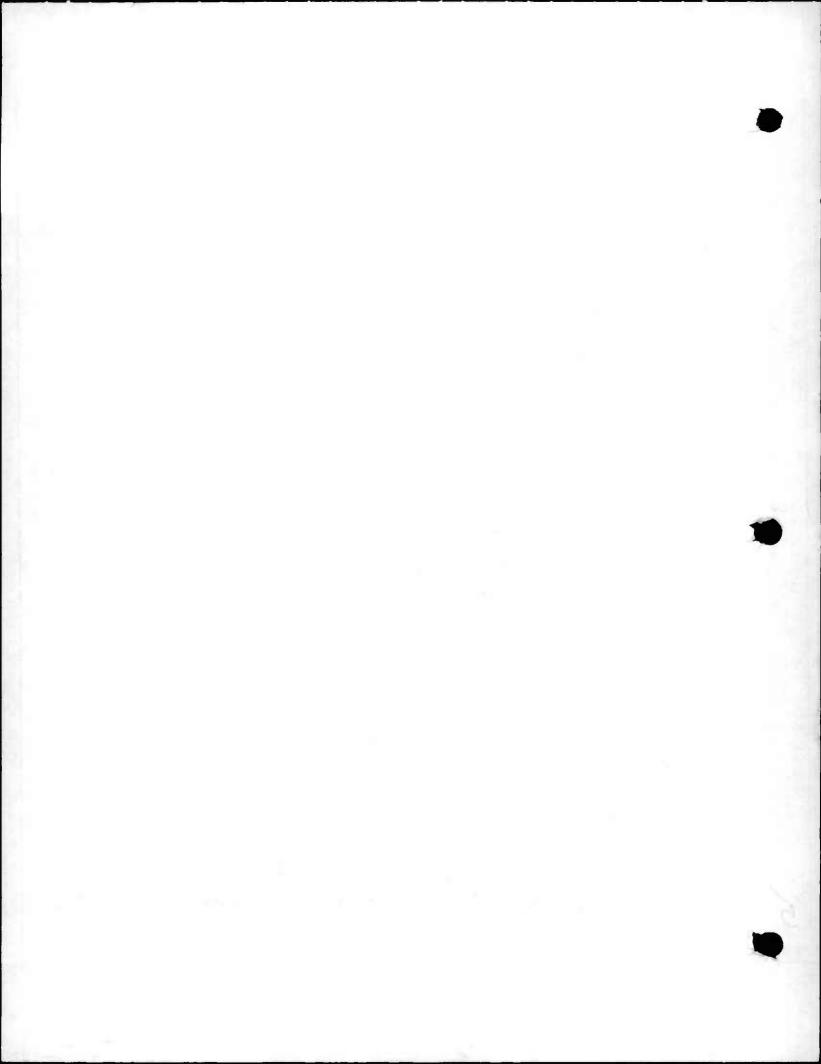
SBALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with now after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fixed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTI	MENT OF HI	EALTH AND I	MENTAL HYGIEN					
- 6	1. DECEDENT'S NAME (First, Middle, Last,	1		71.2 01	BEATT	2. DATE OF DEATH		3. TIME OF DEATH			
	HEDWIG	Horowitz				July 16	1995				
	4. SOCIAL SECURITY NUMBER		O W	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. B	IRTHPLACE (State or Foreign puntry)			
	129-22-2131 9a. FACILITY NAME (If not institution, give	1 DM 2 10 F 9	3 YRS.			5-22-0	11/14	ma, Austria			
S S	1'		Village	1	hers bu		9c. COUNTY C	OF DEATH			
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d.										
DIR		MONTGOMERY ROCKVILLE									
FUNERAL	10e. STREET AND NUMBER 7 KIDKETEID C	MBER 101. ZIP CODE 109. CITIZEN OF WHAT CO									
J. N.	11. MARITAL STATUS										
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 \(\infty\) NO		city, Cuben, Mexica	n, Puarlo Rican, etc.)		ACE — American Indian, Black, White, etc. Specify: WHITE			
8	15. DECEDENT'S ED		16a. DECEDENT'S US	UAL OCCUPATION	t of working	16b. KIND OF BU	SINESS/INDUSTR	ry .			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	HOMEMAK	etired.)	or working	OW	N HOME				
OMI	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Maiden					
BE C	IGNATZ HECHT					STINE SCHW					
101	19a. INFORMANT'S NAME (Type/Print) RUTH TAFT		7 KIRKE	TELD CO	URT - RO	CKVILLE,	n, State, Zip Code MARYLAN	D 20850			
	20e. METHOD OF DISPOSITION 1 Burlel 2 A Cremetion 3 Rer	novel from State 20b.	PLACE AND DATE OF I	DISPOSITION (Nam	ne of		CATION — City o	r Town, Stata , VIRGINIA			
	4 Donation 5 Other (Specify)		. COMPORT								
	· Sole	the standard	-	DANZA 21170 R	NSKY-GOI OCKVTLLI	LDBERG MEMO	ORIAL C KVILLE	HAPELS, INC. MD. 20852			
\Box	23. PART I. Enter the diseases, or	complications that caused	tha death. Do not					Approximata			
	immediate cause (Finel	. List only one cause on ee	ech ilne.	I				interval Between Onset and Death			
	disease or condition reaulting in death)	Coloila	y an	truy (THOSE		·				
_		Anna	CONSCOVENCE OF	the th	2012/16	TRANK					
5	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):	41.							
S	cause, Entar UNDERLYING CAUSE (Disease or injury	· pthe	steum	•							
CERTIFICATION	that initiated eventa resulting in death) LAST	DUE TO (OR) AS A	CONSEQUENCE OF):								
		d									
SAL	PART II. Other significent condition	ns contributing to death bu	it not resulting in t	the undarlying	cause given in	Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
MEDIC						1 TYES 2	NO	OF DEATH?			
2	DID TOBACCO USE CONT	TRIBUTE TO CAUSE OF	F DEATH YES	Пиоп	UNCERTAIN	<u>-</u>		1 YES 2 NO			
NA I	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	2	6. PLACE OF DEATH		OTTOE ICITALI						
PHYSICIAN:	1 TES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Oulpe	itlent 3 DOA	THER: Nursing Home	5 🗆 Residence	6 Other (Specify)					
ву Рн	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	Y WOR		28d. DESCRIBE HOW I	NJURY OCCURED				
1	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY - building, atc. (Specif	— At home, larm, atre	et, factory, office		281. LOCATION (Street a City or Town, State)	and Number or Ru	ral Route Number,			
COMPLETED		SICIAN: To the best of my knowle									
8	296. SIGNATURE AND TITLE OF CERTIFI	ER. On the basis of examination	and/or investigation, i								
TO BE	()	End!	Mo		B36	692	29d. DATE SIGN	(219)			
	30. MANE AND ABORES OF PERSON W	A BEST	TH (ITEM 27) (Type, Pri	Me D	1100	s garany &	me RO,	Coccult SD.			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA				10					
Щ	JUL 20 1991	5 Julia Daviles	Kordall					DHMH.16 Rev 1/89			



2:30

10d. INSIDE CITY

1 XYES 2 NO

MD 20910

Approximate Interval Between

Onset and Death

8. BIRTHPLACE (State or Foreig

China

10g. CITIZEN OF WHAT COUNTRY?

United States

14. RACE — American Indian, Black, White, atc.

White

9c. COUNTY OF OEATH

Montgomery

1995

FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Eduard E. Hellmann July 15, 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 098-32-2142 1 X M 2 - F 73 March 3, funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should Ba. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Oxford Street Garrett Park RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery 4408 Oxford Street FUNERAL 10e. STREET AND NUMBER 4408 Oxford Street 20896 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 X Married 1 TYES 2 X NO Specify BY 3 Widowed 4 Divorced BE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY Elementery/Secondary (0-12) College (1-4 or 5+) National Institutes of Health 5+ Architect 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Ernst Eduard Hellmann Eugenia Poliakowa 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 Hildegund Hellmann Same as 10 pe 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) cemetery, cremetory of other place)
Chesapeake Crematory 7-16 Beltsville, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ellen Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, the cremation, or removal. traumatic event, the medical 23. PART I. Enter the diseases, or complications that claused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, abock, or heart failure. List only one cause on each line. signed by the attending physician and completely filled in by Health and Mental Hygiene prior to burial, cremation, or remo IMMEDIATE CAUSE (Final disease or condition resulting in dasth) Parkinsonism executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate cause. Enter UNDERLYING DR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initisted evants resulting in desth) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 1 YES 2 1 NO s certificate has be, the State Dept. o. PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: 1 TES 2 X NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Rasidence 6 Other (Specify) 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) marked, this c 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending BY 1 YES 2 NO After 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, term, street, tactory, office building, atc. (Specify) 28 is 28t. LOCATION (Street and Number or Rural Route Number, DIRECTOR: / COMPLETED 8 Could not be 4 Homicide if item 29a. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho IMPORTANT: If Ite 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

3941 Ferrara Drive,

12, REGISTRAR'S SIGNATURE all

BE

2

Barry Hecht,

31. DATE FILEO (Month, Day, Year)

JUL 17 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

D 19192

Wheaton, MD 20906

years 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 NO 29d. DATE SIGNED (Month, Day, Year) July 15, 1995 DHMH-16 Ray 1/89

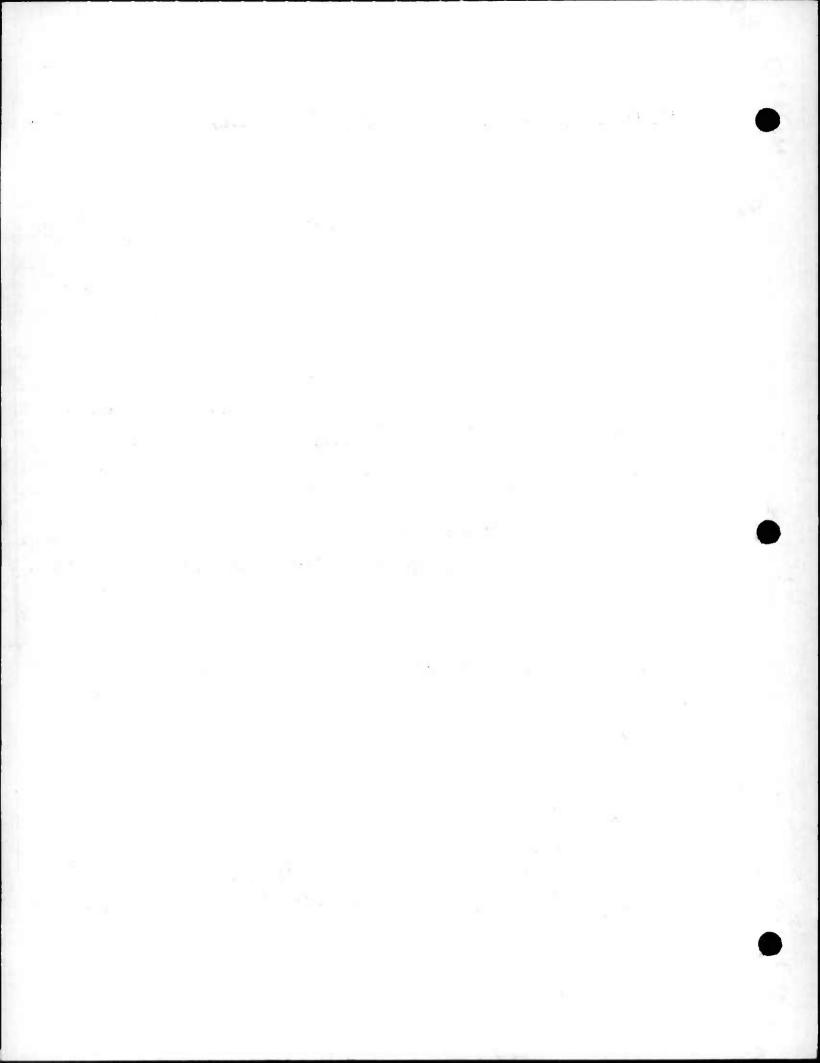
1, 2, 3 should

1 - FOR STATE REGISTRAR

TOTAL TOTAL	TO BE COMPLETED BY DHYSICIAN: MEDICAL CEDTICICATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
he funeral director, page 5 should be detached for use as the burial-transit permit. Pages al.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
ir death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within, 24 hours after death. Page 6 may be retained by the hospital or attending physician.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)	ANN		į.	IED	BURN	2. DATE OF DEAT	3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER	6. AGE (In yrs. Is				JULY 13 1995			5:45 Am				
	218-38-6489		5. SEX	55		NTHS DAY		7. DATE OF BIRTH (Month, Day, Vol. May 3,	1940	Countr	PLACE (State or Foreign y) nington, D.C.		
	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DI									_			
FUNERAL DIRECTOR	Greater Western Maryland Medical Center Hagerstown Washington												
RE	10a. STATE	10c. CITY, T	OWN OR LO	CATION				10d. INSIDE CITY LIMITS?					
L D	Virginia 100. STREET AND NUMBER	We	stmorela	nd	<u> </u>		ial Beach			1 ☐ YES 2 🔀 NO			
ERA	401 Livings	tone S	treet		10f, ZIP CODE 10g, CITI						U.S.A.		
N D	11. MARITAL STATUS		12. WAS DECEDEN			13. WAS D	ECENDENT OF HISPAN	IIC ORIGIN? (Specif	Yea or No-		E — American Indian, c, White, etc.		
ВУ	1 Never Married 2 1 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married 2 Nover Married		FORCES? 1		NO If yes, specify Cuban, Maxican, Puarto Rican, etc.) Blac 1 YES 2\(\subseteq \text{NO} \) Specify: Specify:								
		EDENT'S EDU		16a. Di	ECEDENT'S US	UAL OCCUPA	TION	16h KIND OF	BUSINESS/IN	Whi	ite		
	(Specify only Elementary/Secondary (0	y highest grade 1-12)	completed) Cotlege (1-4 or 5	(0	Give kind of worl e. Do NOT use n	done durina	most of working						
COMPLETED			2		Secreta	ry			nal Geo	ograp	hic		
BE CO	17. FATHER'S NAME (First, M Daniel John		Jr.					ME (First, Middle, Me Frances		son			
6	19a. INFORMANT'S NAME (7						t and Number or Rural I				20902		
	Brad Cari						ity Blvd.						
	1 X Buriel 2 Cremation 4 Donation 5 Other	n 3 🗆 Rem	oval from State	cemetery co	ematory or other	nlecal			LOCATION —		wn, State ng, Maryland		
	21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE	Toate	OI HEA	22. NAME	AND ADDRESS OF FA	CILITY					
	· Man	+	10	11			is J. Col				Inc. ,MD 20901		
	23. PART I. Enter the di	seasea, or o	complications the	t caused the d	eeth. Do not	enter the r	node of dying, auc	h ea cerdiac or n	espiratory an	rest,	Approximete		
	IMMEDIATE CAUSE (Fin		D .								Interval Between Onset and Deeth		
	resulting in death)	→	DUE TO	(OR AS A CONSE	OUENCE OF:				- 70	1-2 days			
z	END STAGE MULTIPLE SCLEROSIC YEARS												
	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING										151115		
임	CAUSE (Disease or Inju		cDUE TO	(OR AS A CONSE	OUENCE OF):								
CERTIFICATION	resulting in deeth) LAS	' L	d										
_	PART II. Other algorificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY FINDINGS												
EDICAL	CONGES							PER	FORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
ME	NEPHR	DLIT	HIASIS		•						OF DEATH? 1 ¥YES 2 □ NO		
Ä	DID TOBACCO U		RIBUTE TO CA					1 🗆					
PHYSICIAN	25. WAS CASE REFERRED TO EXAMINER? 1 ☐ YES 2 M NO	D MEDICAL	HOSPITAL:	26. PLA		THER:							
Ë	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. TIME O	F 28c, I	MA 5 Realdence	6 Other (Specify) 28d. DESCRIBE HO	W INJURY OC	CURED			
BY		Pending Investigation	(Month, D	ay, rear)	INJURY		YORK?						
		Could not be determined	28e. PLACE O building,	F INJURY — At he atc. (Specify)	ome, farm, atre-	et, factory, of	Ica	281. LOCATION (Str City or Town, S	eet and Number fate)	or Rural A	oute Number,		
7	29a. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the beat of	my knowledge, de	eath occurred a	t the time, da	te end place, and due	to the cause(a) and	menner en stet	ed.			
291. LOCATION (Street and Number or Rural Route Number, City or Town, State) 292. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beat of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner.										and manner as stated.			
BE	29b. SIGNATURE AND TITLE	OF CERTIFIER	01 01	0 1 0 0	MID.		29c. LICENSE NUM	BER	29d. DAT	E SIGNED	(Month, Day, Year)		
2	30. NAME AND ADDRESS OF	DEBEON WIT	D COMPI STORY	MM,	VI D'		10-465	77	•	1/13	3/1995		
	SIRAT	SID	DIQUI	M N 1 C	M 27) (Type, Pri		AVENUA	HACE	RCPA	MAIN	MD-21742		
	31. DATE FILED (Month, Day,	Year)		R'S SIGNATURE		- 1	,	- / 1111016	10	44/0	TO		
	IH-	7 199	Julia d	auchor Ro	rdall								



DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: Il item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	THE THE	THE THE	MPOR

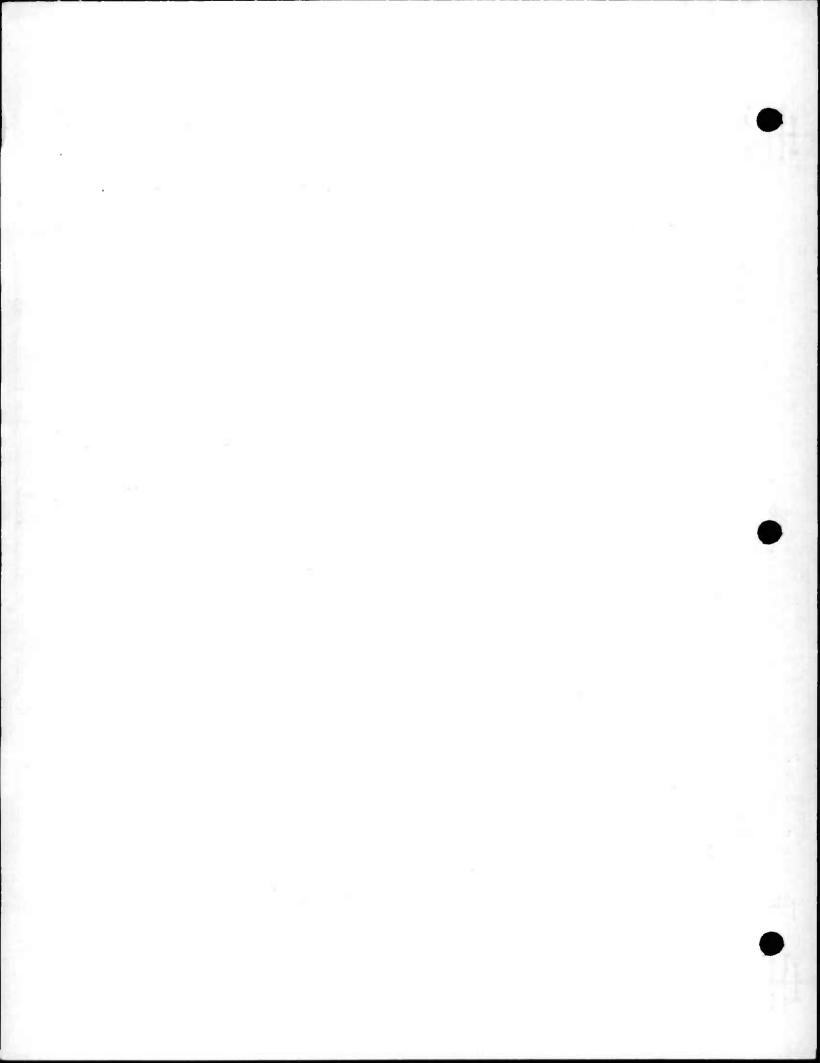
1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEATH	
	Viola	Kr	oeh1	U	2000					MONTH	DA		YEAR		
	4. SOCIAL SECURITY NUME		5. SEX		argan rs. last birthday)	F 12-	DER 1 YEAR	IF UNDER		July 7. DATE OF 8	16	1	1995 10:00 I		
	086-05-246		1 M 2 F			MONTH	_		MIN.	(Month, Da	y, Year)		Count	(ry)	
			41	89	y THS.					April	4, 1	906	New	Jersey	
~	9a. FACILITY NAME (If not in	stitution, give s	treet end number)			9b, CI	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH					DEATH			
DIRECTOR	Brooke Gro	ove Nu	rsing Ho	ne			Sandy Spring Montgomery				merv				
ច្ឆ [Brooke Groove Nursing Home RESIDENCE OF DECEMENT 100. STATE 10b. COUNTY				1										
<u> </u>	1000 0000												10d. INSIDE CITY LIMITS?		
	Maryland Montgomery Rockville									1 TYES 2 X NO					
FUNERAL	10e. STREET AND NUMBER					101. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?					
	13506 Dowlais Drive						20853				USA				
5	11. MARITAL STATUS 12. WAS DECEDENT EVER					1	3. WAS DE	CENDENT C	F HISPAI	NIC ORIGIN? (S	pecify Yee	or No-	14. RAC	E — American Indian,	
BY	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE V		ES 2 NO R DATES			ipecify Cuba S 2 🔯 NO		in, Puerto Ricar	i, etc.)		Spec	k, White, etc.	
	3 La Widowed 4 Dive	rced						-					-	White	
ш	15. DEC (Specify only	EDENT'S EDU	CATION completed	16	e. DECEDENT'S	S USUAL	OCCUPAT	ION	121	16b. KIN	D OF BUS	INESS/INI	DUSTRY		
<u> </u>	Elementary/Secondary (0		College (1-4 or 5	+)	life. Do NOT u	ise retired	t.)	POST OF WORKE	N.						
₫			4		Homem	ake	r			Ow	n Hoi	ne			
COMPLETED	17. FATHER'S NAME (First, M	iddle, Last)						18. MOTI	HER'S NA	ME (First, Middle					
	Unknov	vn.						1		nown		,		1	
BE	19e. INFORMANT'S NAME (7				19b. MAILING	G ADDRE	SS (Street	and Number		Route Number, C	The or Town	Chain 7is	Code)		
임	Roberta T. H	Ceady								Rockvi			208.	53	
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	1 X Burlel 2 - Crematic	n 3 🗆 Rem	oval from State	aamatas			-1		_	DATE					
ł	4 ☐ Donation 5 ☐ Other 21. SIGNATURE OF FUNERA		ENGEE	- Gat	e or H	eaven Cemetery 7/19/95 Silver Spring, MD							ng, MD		
	21. GIGHAR OF POWERS	C SERVICE LIC	CHOSEE (curv 11ins 1	Fune	ral R	Home	Inc	
	dam	5 51	w) and	ne						y Blvd					
IMMEDIATE CAUSE (Finel disease or condition reaulting in death) Due to (or as a consequence of):										Interval Between Onset and Death					
CERTIFICATION	thet initiated events	CAUSE (Disease or Injury thet Initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST													
- 11	PART II. Other significe	nt condition	e contributing to	deeth but i	not regulting	in the	underlylr	ag ceuse c	ilven in	Port I 24s	. WAS AN	UTTOREV	746	. WERE AUTOPSY FINDINGS	
EDICAL	Peluio	K	Hio	2-		07		.9 00000 3	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		PERFORI	MED?	240	AVAILABLE PRIOR TO	
הַ <u>ו</u>			etra		0					10	YES 2	MO		OF DEATH?	
ξ														1 - YES 2 - NO	
ž II	DID TOBACCO U		RIBUTE TO CA	USE OF I	DEATH Y	ES 🗆	NO [UNC	ERTAI	4 D					
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26.	PLACE OF DEA)							
2	YES 2 NO		1 Inpatient 2	ER/Outpatie	nt 3 🗆 DOA	QT/fi		me 5 □ Re	sidence	6 Other (Sp.	ec/fv)				
=	27. MANNER OF DEATH		26e. DATE OF		26b. TIN	E OF	28c. IN	JURY AT		28d. DESCRIE		JURY OC	CURED		
SII		Pending nvestigation	Month, D		1	JURY M		YES 2	(ND	3	011				
6	2 Suitelds	_	26e. PLACE O	F INJURY —	At home, term,	street, to	ctory, offi	ce	`	261. LOCATIO	N (Street or	nd Number	or Rural I	Poute Number	
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4	29e. CERTIFIER	T. Carrier			BHOW	-					143	100	1/6	wy.	
COMPLE	(Check only		CIAN: To the best of R: On the basis of er) end menner ae stated.	
	29b, SIGNATURE AND TITLE	OF CERTIFIE					-	29c. LICE	NSE NUA	MBER		29d. DAT	E SIGNED	(Month, Day, Year)	
20	20	(-	7	L.			7	Dr	2	147		•	1		
2 ∦	30. NAME AND ADDRESS OF	PERSON WHI	O COMPLETED CALL	E OF DEATH	(ITEM 27) / h/m	Print	_	1-0		216		-	Jen	4 18 11	
	7	-	1	DENIN	(. r.m 21) (19/06		DI	101	C -		6.		3	Extroday.	
-	31. DATE FILED (Month, Day,	S ther	32. REGISTRA	Die elenarii	05	2	. 0	91	> 0	On >1	2	1	400	mg	
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		4 7010C	1 (1.11" 13	5	60 A										

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3. TIME OF DEATH

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8. BIRTHPLACE (State or Foreign

West Virginia

F VITAL RECORDS, P.O. BOX 68760	SICIAN: The law requires that the death certificate be executed think of hours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and co., "celly filled in by the funeral director, page 5 should be detached for use as the burial-transit in the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	I, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL OR ATTENDING PHYSICIAN: The

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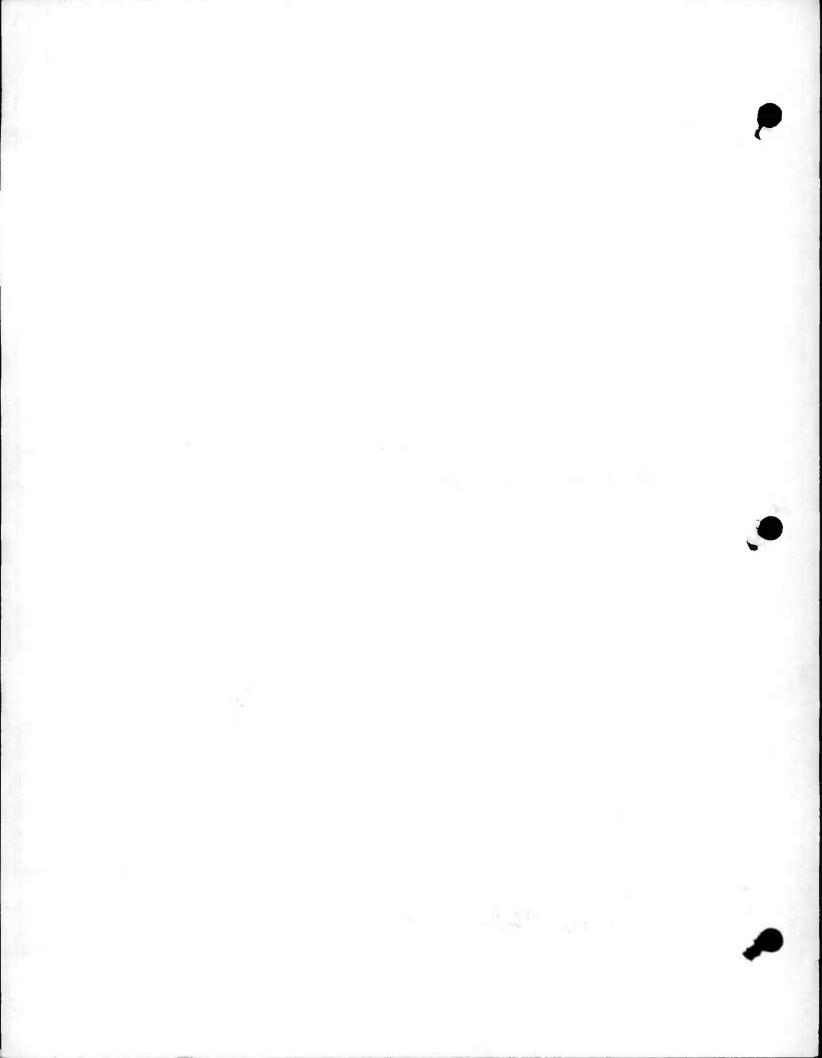
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Pages 1, 2, 3 should

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH JŪLŸ 17, 1995 WARREN GAMALIEL HARE 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 705-12-6565 1 X M 2 - F 74 March 11 9e. FACILITY NAME (If not institution, give street end number) b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Sacred Heart Hospital Cumber land RESIDENCE OF DECEDENT 10e STATE 10c. CITY, TOWN OR LOCATION WV Mineral Keyser FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 1365 Terri Street 26726 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Ricen, stc.) 1 Never Married 2 Merried ВY 1 YES 2 NO Specify: 3 Widowed 4 Divorced WW II COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 12th Conductor 17. FATHER'S NAME (First, Middle, Last) Robert T. Hare BE Grace Fawver 19e. INFORMANT'S NAME (Type/Print) 2 Jacquelin R. Hare 1365 Terri Street, Keyser, WV 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE Burlal 2 Cremetion 3 Re Donetion 5 Other (Specify) Carmel Cemetery 7/20/95 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Harold Nean 120 ahock, or heart failure. List only one cause on each line. **IMMEDIATE CAUSE (Final** disease or condition resulting in death) CERTIFICATION Sequentially list conditions. if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL ASCUD Wind 1 TES DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🔀 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 TES 2 NO OTHER: Inpatient 2 - ER/Outpatient 3 - DOA ng Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH

Allegany 10d. INSIDE CITY 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 14. RACE — American Indian, Black, White, etc. White 16b. KIND OF BUSINESS/INOUSTRY Transportation 18. MOTHER'S NAME (First, Middle, Meiden Surname) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. LOCATION - City or Town, State Aurora, West Virginia Markwood McKenzie Funeral Home 111 S. Mineral Street, Keyser, WV 26726 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Betw Failure-Renal Rulin Carda Onset and Death my 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY OF DEATH? 1 YES 2 NO 28s. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED Natural 5 Pending investigation м 1 YES 2 NO Accident 26e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 26f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) end menner ee stated. 296. SIGNATURE AND THE OF CENTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 3ADUUM) 200 7/35 JULY / 1995 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MAZZOCCO, V. EUGENE, M.D. BMG, 912 SETON DRIVE CUMBERLAND, MD. 21502 REGISTRAR'S SIGNATURE



examiner must be notified at once.

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit nermit. Panes 1, 2, should
be filed within 72 hours after death with the State Dept, of Heatth and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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95 23365 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 July Samantha Marie Higdon 16 7:45 Am 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTN 6. BIRTHPLACE (State or Foreign IF UNDER 24 HRS (Month, Day, Year), 1994 Maryland 216-41-5456 1 M 2 X F Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 5917 Fisher Road Apt# 13 Temple Hills Prince George's RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Maryland Prince George's Temple Hills 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5917 Fisher Road, Apt. #13 20748 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-If yee, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 NO Specify: 14. RACE — American Indian, Block, White, etc. 1 Never Married 2 Merried В Spec#White 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION BE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) N/A ntary/Secondary (0-12) College (1-4 or 5+) None N/A 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) James Edward Higdon, III Barbara Ann Dixon 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 James Edward Higdon, III 5917 Fisher Rd., #13, Temple Hills, Md. 20748 20a. METHOD OF DISPOSITION
1 \(\Delta \) Burlal 2 \(\Bar\) Cremetion 3 \(\Delta \) Re 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Resurrection Cemetery 7/18/95 4 Donation 5 Other (Specify) Clinton, Maryland Ceorge P. Kalas Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSE 6160 Oxon Hill Rd. Oxon Hill, Md.20745 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or heart failure. List only one cause on Interval Retwe IMMEDIATE CAUSE (Final Onset and Daath disease or condition resulting in death) angerhans ear BY PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE YES 2 NO OF DEATH? 1 TYES . X MA

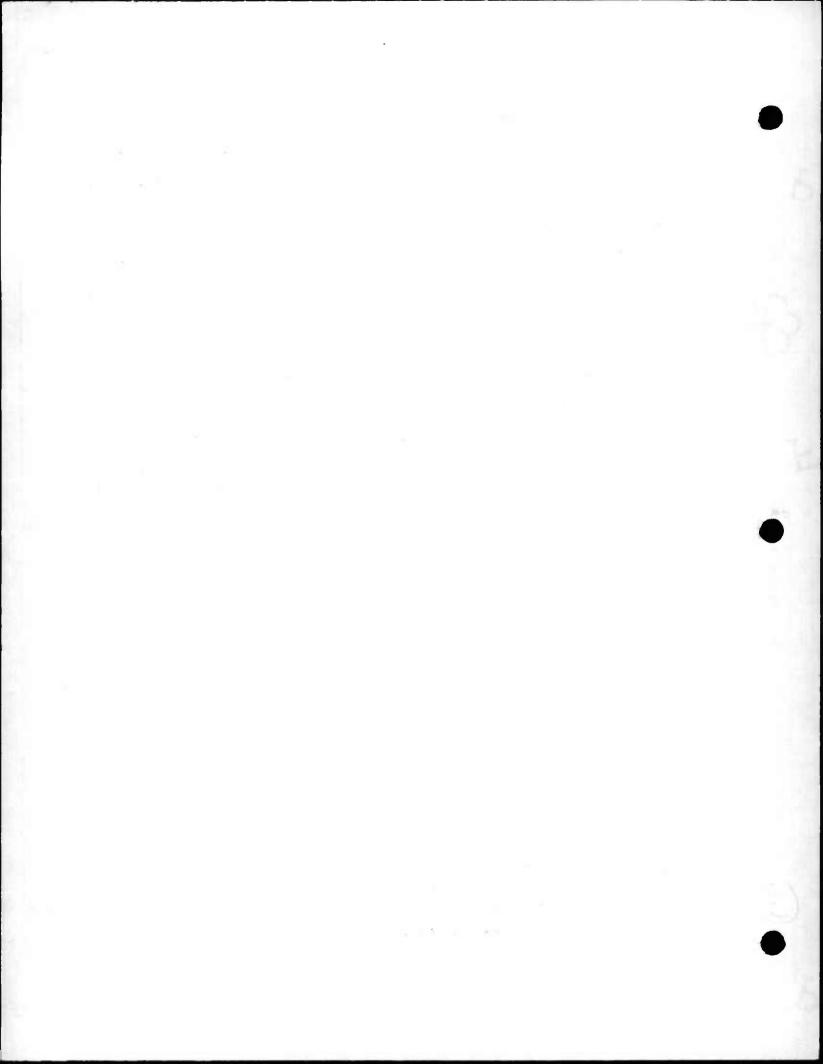
DID TOBACCO USE CONTI	N D					
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		E OF DEATH (Check				
1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	6 ☐ Other (Specify)				
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DEŞCRIBE NOW INJURY OCCUREO		
3 Suicide 6 Could not be 4 Homicide datarmined	28a. PLACE OF INJURY — At hor building, etc. (Specify)	me, farm, street, fac	ctory, office	281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)		

1 KCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis

nd/or Investigation, in my opinion, death occured at the time, date and pieca, and due to the cause(a) and manner as stated.

9c. LICENSE NUMBER

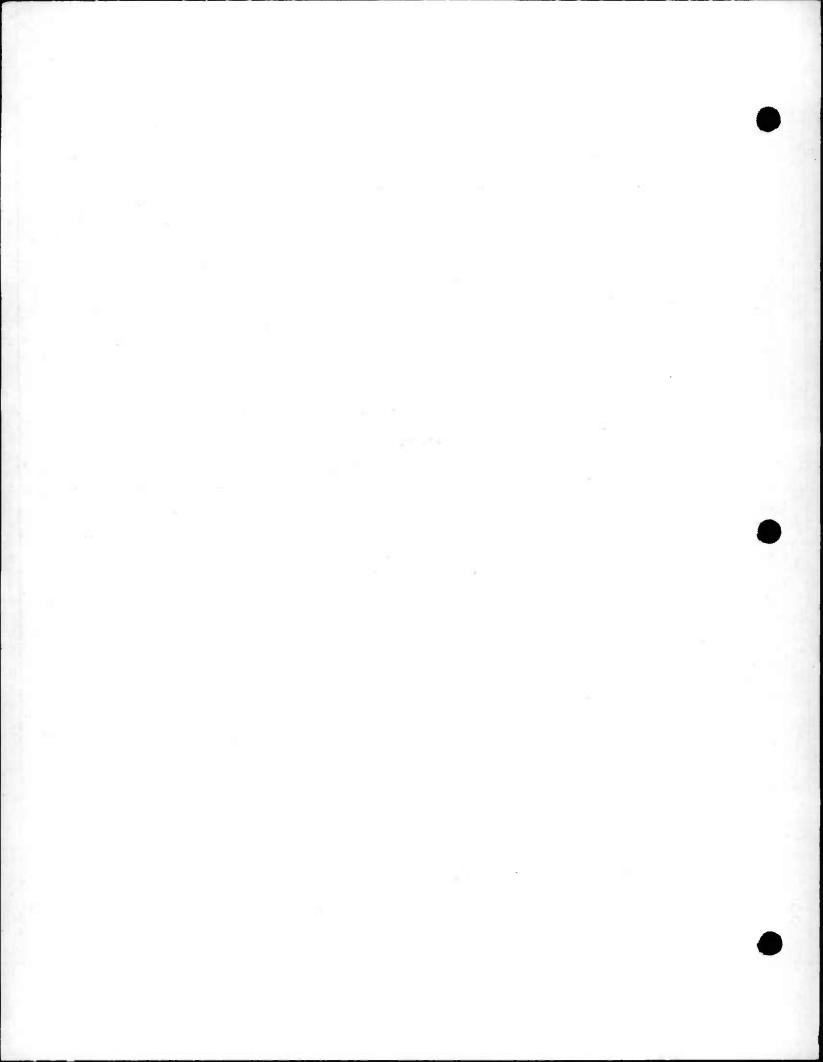
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		1 - STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
		1. DECEDENT'S NAME (First, Middle, Last)	Incolas					2. DA	TE OF DEATH	DAY	YEAR	3. TIME OF DEATH 2:10 A.
Pir		4. SOCIAL SECURITY NUMBER 156-05-5140	in yrs. lest birthdey) 4 YRS.	F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Ybar) NEW YO					LACE (State or Foreign			
2, 3 should	TOR	99. FACILITY NAME (If not institution, give HEBREW HOME OF GI		GTON		96. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE MONTGOMERY						
permit, Pages 1,	DIRECTOR	10a. STATE 10b. COUNT	GOMERY			V, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 X YES 2 \[\square\$ N						10d. INSIDE CITY LIMITS?
ALTIMORE, MARYLAND 21215-0020 death. Page 6 may be retained by the hospital or attending physician. In mental director, page 5 should be detached for use as the burial-transit examiner must be notified at once.	FUNERAL	100. STREET AND NUMBER 6111 MONTROSE ROA	AD		101. ZIP CODE 109, CITIZEN OF WHAT COUNTY 20852 UNITED STAT							
	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	U.S. ARMED 2XXVO ITES	S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No.— 14. RACE— Black, V Blac					American Indian, White, etc.			
	LETED	15. DECEOENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	College (1-4 or 5+) (Give kind of work done during life. Do NOT use retired.)			CUPATION 166 KIND OF BUSINESS/INDUSTRY					
	E COMPL	17. FATHER'S NAME (First, Middle, Last) HARRIS HOROW	TZ		WNE	<u> </u>	18. MOTHER		MILL,	en Surname)	TORE	
	TO BE	19e, INFORMANT'S NAME (Type/Print)	(DANGUMUD)							own, State, Zip C		
	-	MARYLIN KRUPSAW 20a. METHOD OF DISPOSITION 1X Burtal 2 Committion 3 X Flam	(DAUGHTER)	PLACE AND DATE				1		DMAC, M		
		4 Donation 5 D Other (Specify)		MI. HER	RON	CEME	ГERY	7/		USHING		
		21. SIGNATURE OF FUNERAL SERVICE LI	In Jui		DA	ANZAN		LDBER		ORIAL C		LS, INC. D 20852
withous all withouts all pletely filled in the cremation, or mine vent, the imedial		23. PART I. Enter the diseases, or shock, or hear failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. DUE TO (QR AS A	S	not enta	r the mod	da of dying,	such as ca	ardlec or res	piratory srres	st,	Approximate interval Between Onset and Deat
P.O. BOX 68: th certificate be execute ending physician and or Hygiene prior to buria or other traumatic	ERTIFICATION	Sequentially list conditions, if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evants resulting in deeth) LAST	b. OUNG YOU DUE TO (OR AS A d.								Stady	
RECORDS, P requires that the death even signed by the atten of Health and Mental Is shows any injury, or	MEDICAL CE	PART II. Other significant condition Newlord CND 1994 A	s contributing to death bu	it not resulting	In the u	nderlying	ceuse giver	n in Part I.		AN AUTOPSY ORMED?	A C	VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 \(\begin{array}{c}\) NO
law law Dept		DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL				ио □	UNCERT	AIN 🗆				11
ate ate	PHYSICIAN:	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outpa	tient 3 DOA	OTHE	R:	5 - Resider	nce 6 Ott	her (Specify)			
NO OF VI NG PHYSICIAN: tter this certifica eath with the St marked, or it		27. MANNER OF OEATH 1 Miturel 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIN		26c. INJU WOF	IRY AT	28d. O		V INJURY OCCU	REO	
TSIC TTENDII TTOR: A after de 28 is	ETED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	street, fac	M 1 YES 2 NO reet, factory, office 281. LOCATION (Street and City or Town, State)				et and Number or te)	Rural Rou	te Number,		
A 4 2 5	COMPLE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated.										nd manner as stated,
TO THE HOSPIT TO THE FUNERA DE filed within 7 IMPORTANT: I	TO BE C	296, SIGNATURE AND TITLE OF CERTIFIE	te mo			29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 1714 16 1995						
	-	30. NAME AND ADDRESS OF PERSON WH	COUNTED CAUSE OF GEA	TH (ITEM 27) (Type	MPU	ical	Pir	KL	1 5	rike	Spirit	y, Myzo

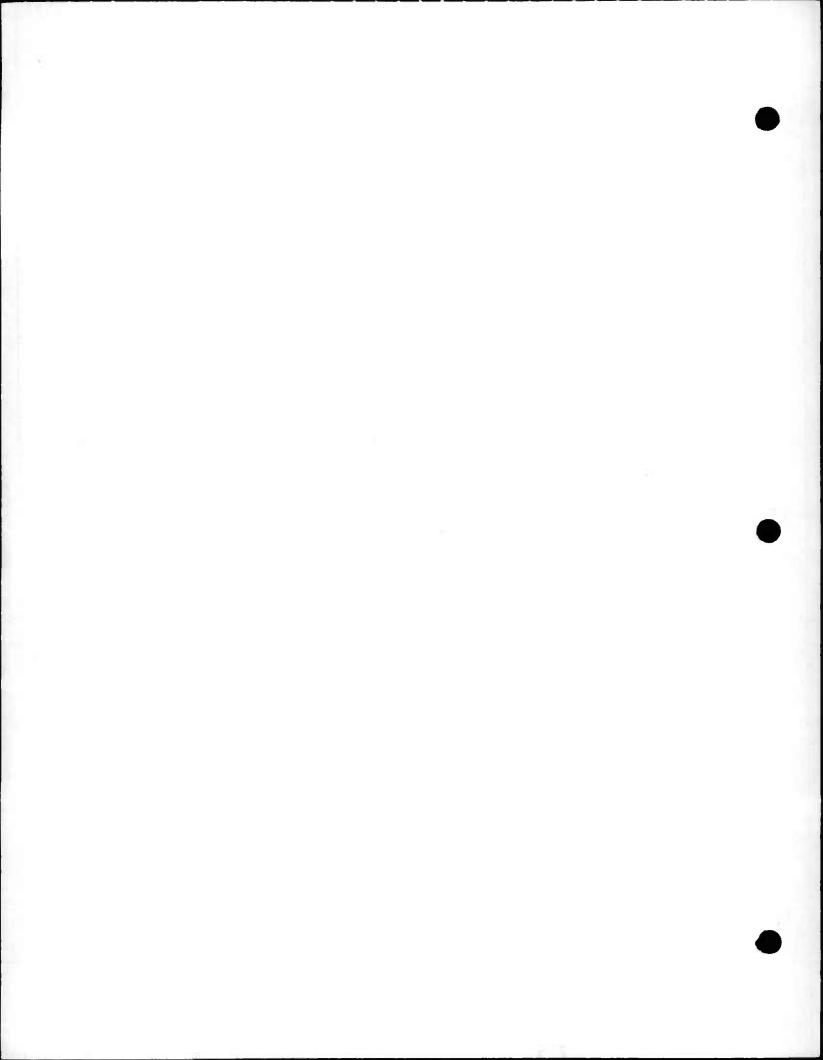
SE RECHETRAN'S SIGNATURES



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Bery/ Rankin
4. SOCIAL SECURITY NUMBER 190) CL V 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 217-34-0835 102 YRS. Nov. 6. Nebraska permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Brooke Grove Nursing Home 01ney Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Silver Spring Montgomery 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 3294 Gleneagles Drive 20906 United States hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ∑NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yee, specify Cuban, Mexicen, Puerto Rican, etc.) BALTIMORE, MARYLAND 21215-0020 14. RACE — American Indian, Black, White, atc. 1 X Never Merried 2 Married BY 1 YES 2 XNO Specify: Specify: 3 Widowed 4 Divorced White ETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe College (1-4 or 5+) Elementary/Secondary (0-12) COMPL 12 Musicologist Education 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) notified at James Burrell Jeter Harriet Loretta Rankin BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 David Alan Reid 706 Seneca Road, Great Falls, Virginia 22066 pe 200. METHOD OF DISPOSITION 20b. PLACEAND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 20e. METHOD OF DISPOSITION

1 Burlel 2 X Cremation 3 Removal from State

4 Donation 5 Other (Specify) cometery, cremetory or other place)
Fort Lincoln Crematory 7/17 Brentwood, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Hines-Rinaldi Funeral Home, Inc. all a 700 11800 New Hampshire Ave., Silver Spring, MD the medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, n and completely filled in by to burial, cremation, or remo ahock, or haart fallure. List only one cause on sech line 0 Interval Betw **IMMEDIATE CAUSE (Finel** Onset and Death Cardia Arrest secondary to Cargostin Cardeonype disease or condition resulting in death) Much event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 10 years traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate physician ne prior to death certificate be cause. Enter UNDERLYING CAUSE (Disease or injury other signed by the attending phy Health and Mental Hygiene that initiated evants DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 5 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? Paroxys was Agreal Febrillaten 1 TYES 2 ANO t. of Heat OF DEATH? 1 YES 2 -NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO INCERTAIN PHYSICIAN: has by Dept. 23 25. WAS CASE REFERRED TO MEDICAL OR ATTENDING PHYSICIAN: The 26. PLACE OF DEATH (Check only one) certificate to the State HOSPITAL: OTHER: 1 TES 2 NO Inpatient 2 DER/Outpatient 3 DOA 4- Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? marked, 26d. DESCRIBE HOW INJURY OCCURED this 1 Natural 5 Pending 1 YES 2 NO BY After 2 Accident 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 69 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 8 Could not be DIRECTOR: 4 Homicide 28 item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. COMPL TO THE FUNERAL OF THE FUNERAL OF THE WITHIN 72 H HOSPITAL 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data end place, end due to the ceuse(e) and menner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Witemno 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A Cersan Cylol Glad Due Horn MA 28 006 GARREN S. FERRY 3305 32. BEGISTRAR'S SIGNATURE Julia Davidson Rendall



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

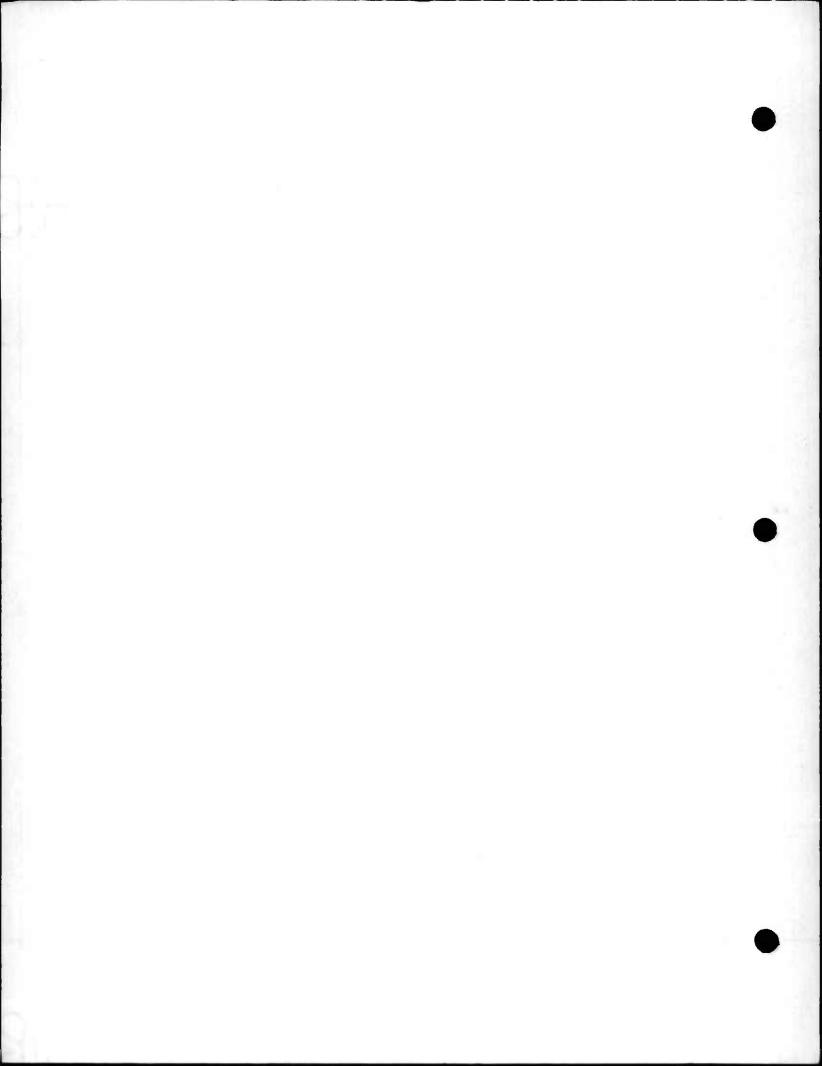
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)						-		2. DATE OF	DEATH			3. TIME OF DEATH
1 2	Henry Ell	a Jack	cson								July 17, 1995 YEAR 6:5			
1	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. le	st birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			7 DATE OF	7. DATE OF BIRTH 8. Bit (Month, Day, Year) Co			HPLACE (State or Foreign	
	429-46-040		1 🗌 M 2 💢 F	8	9 YRS.	MONTHS	DAYS	HOURS	MIN.	Nov.			Ark	cansas
_	9e. FACILITY NAME (If not in						96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF					JNTY OF D	DEATH	
2	Wilson He		Care Cent	er		(GAit	nerst	ourg			Mon	ntgon	nery
DIRECTOR	10e. STATE	10b. COUNT	Υ		10c. CI1	TY, TOWN	OR LOCA	TION		-	-	10d. INSIDE CITY		
12	Maryland	Montg	gomery		Rockville							LIMITS?		
IAL I	10e. STREET AND NUMBER				10f, ZIP CODE					10g. CI1	TIZEN OF V	WHAT COUNTRY?		
FUNERAL	15113 Emor	y Lane	2		20853					United States			States	
E	11. MARITAL STATUS 1 Never Married 2	Merried	FORCES?	T EVER IN U.S. AI	RMED NO	13.	il yes, sp	ecity Cube	n, Mexica	NIC ORIGIN? (S in, Puerlo Rica	specify Yes n, atc.)	s or No— 14. RACE — American Indien, Bleck, White, etc.		
BY	3 🖟 Wildowed 4 🗌 Divorced IF YES, GIVE WAR OR OATES						1 TYES	2 X NO	Specif	y:			Spec B1a	
COMPLETED	15. DEC	EOENT'S EDU	CATION completed)	16e. Di	ECEOENT'S	USUAL C	CCUPATIO	ON of worki		16b. Kil	ND OF BUS	SINESS/IN		
19	Elementary/Secondary (College (1-4 or 5	+)	i. Do NOT u	se retired.)	during me	OSE OF WORKH	ng					
MP	7			H	ousev	vife				Нот				
	17. FATHER'S NAME (First, M John Jacks							l .		ME (First, Midd	lle, Malden	Sumeme)		
H	19a, INFORMANT'S NAME (140	b MAII IN	ADDRES	e (Ct	_		Dowell Route Number,	O15 T.	- 0:		
2	Jennie War									ckvill			0853	
	20a METHOD OF DISPOSIT	ION		20b, PLACE	ANODATE	OF OISPO	SITION /N/	ame of		DATE	7		- City or To	own, State
١.	4 🗆 Donellon 🄞 📝 Other	(Specify)	1000	cemetery, cri	ony 1	lemon	ial	Park	ζ	7/21	Lar	ndove	er, M	Maryland
1	21. SIGNATURE OF PENEGRA	SERVICE LI	CENSEE	14/		22. MC	NAME A	ND AOORE	SS OF FA	al Ser	vice	Tne	,	20012
	1	Core	en E.	1/10	elh	74	400 (Georg	gia A	Ave. N	.W.,	Wash	ningt	on, D.C.
	23. PART I, Entar tha d	iseases, Dr	complications the	it coused the d	eath. Do									Approximate
10	ehock, or heert fallure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Finel Onset and Death													
	disease or condition a. Congestive Heart Foilure 24 hrs													
	DUE TO-OR AS A CONSEQUENCE OF):													
NO N	Sequentially list conditions, Due to (or as a consequence of): Due to (or as a consequence of):													
CAT	cause. Enter UNDERLY	cause. Enter UNDERLYING											į	
Ĕ	CAUSE (Disease or Injute that initiated events		DUE TO	(OR AS A CONSE	OUENCE O	IF):								
CERTIFICATION	resulting in death) LAS	T .	d											
	PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY ENDINGS													
MEDICAL	Anemi	Anomia Probable armulacutic Performed? Available Prior to Completion of Cause												
	BUKEMIA, Cerebral arteriosclarosis													
1 1	DID TOBACC				SE O	DEA	TH	ES [N) [X				
PHYSICIAN:	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:			OTHE	_	LACE OF C	EATH (Ch	eck only one)				
YSI	1 TYES 2 NO		1 Inpatient 2				rsing Hon		ssidence	8 🗆 Other (Sp				
	27. MANNER OF DEATH	Pending	26e. DATE Of (Month, L		28b. TIA	JURY	WC	DRK?	7	26d. OEŞCRI	BE HOW I	NJURY O	CCURED	
B	2 Accident	Investigation	28e. PLACE C	OF INJURY — At he	ome lerm	etraet les		YES 2	_ NO	281 LOCATIO	M (Street a	and Mumba	or Burni i	Route Number.
		Could not be determined	building	etc. (Specify)	ane, rarin,	acreet, rec	iory, ome	•			own, State)		or Hurar I	Houte Number,
9	29e. CERTIFIER 1 CERT	TIEVING PHYS	(CIAN: To the best of	ew knowledge d	ath annum	and at the	time dete	and alone		4- 1h				
COMPLETED			ICIAN: To the best of ER: On the besis of a											e) end manner ee stated.
	295, SIGNATURE AND TITLE			0-					ENSE NUI					(Month, Day, Year)
B		TOA	Second	VM	2 S		MP		72	31		D _	Alsa	17.1995
2	30. NAME AND AGORESS OF	F PERSON-WI	10-COMPLETEO CAU	SE OF DEATH (ITE	M 27) (Type	, Print)	مارس		7 08			~	WI W	1 11113
	James R.	mo	predr.	207 F	300	Ms.	s A	ve !	Ga	: thes	sbu	.00	mo	,20877
	31. DATE FILED (Month, Day,	Year)	32 REGISTRA	AR'S SIGNATURE								3		The second second second
	JUL 19	1995	fulla da	vilson Ran	lall									



1995

3. TIME OF DEATH

PM

9:15

New York

9c COUNTY OF DEATH

B. BIRTHPLACE (State or Foreign

BALTIMORE, MARYLAND 21215-0020	e law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physici	has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-I Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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AL RECORDS, P.O. BOX 68760	8	has been signed by the attending physician and completely filled in by the fi Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Pages 1, 2, 3 should

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Injury, or other traumatic

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marked,

69 DIRECTOR: A

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PHYSICIAN: Item 23 s

BY

COMPLETED

BE

2

25. WAS CASE REFERRED TO MEDICAL

5 Pending

8 Could not be determined

Saia,

M.D.

1 ☐ YES 2 NO

S.

31. DATE FILEO (Month, Day, Year)

JUL 18 1995

J6hn

27. MANNER OF DEATH

1 X Natural

2 Accident

3 Suicide

4 Homicide

HOSPITAL:

ara

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1 Inpatient 2 ER/Outpatient 3 DOA

32 REGISTRAR'S GIGNATURE

28e. DATE OF INJURY (Month, Day, Year)

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Anthony Charles Kirchgessner July 16, 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 1 📈 M 2 🗌 F 051 16 5557 Aug. 15,1922 Sa. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 17712 Little Haven Lane Olnev RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION Maryland Montgomery Potomac FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 9313 Orchard Brook Drive 20854 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea, specify Cuben, Mexican, Puerto Rican, etc.)
 U YES 2 NO Specify: FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried В 3 🔀 Widowed 4 🗌 Divorced World War 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Saleman 17. FATHER'S NAME (First, Middle, Last) Anthony Kirchgessner Pauline 盟 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Anthony P. Kirchgessner 17712 Little Haven Lane, Olney, Maryland 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetery or other place) July 19, 1995 OATE 1 ☐ Buriel 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Inc. Montgomery 21. SIGNATURE OF FUNERAL SERVICE THERESE M00689 23. Part I had diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition Respiratory Failure resulting in death) QUE TO (OR AS A CONSEQUENCE OF): Severe Metastatic Leiomyosarcoma CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events reaulting in death) LAST PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL Cancer of Prostate, COPD, CAD

26. PLACE OF DEATH (Check only one)

28e. PLACE OF INJURY — Al home, ferm, streef, fectory, office building, etc. (Specify)

28c. INJURY AT

1 YES 2 NO

D10493

Montgomery 10d. INSIDE CITY 1 - YES 2 - NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, atc. Specify: White 16b. KIND OF BUSINESS/INOUSTRY Commercial Sales 18. MOTHER'S NAME (First, Middle, Meiden Surneme) Muller 20832 20c. LOCATION - City or Town, State Bethesda, Maryland 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, MD 20814-3501 Interval Between Onaet and Death 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 4 ☐ Nursing Home 5 ☑ Rasidence 8 ☐ Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, 12 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, data end place, and dua to the cause(e) end menner as stated. MEDICAL EXAMINER: On the beets of examination end/or investigation, in my opinion, death occurred at the time, date end placa, end due to the cause(e) and menner es stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) July 17, 1995 809 Veirs Mill Road, #101, Rockville, Maryland 20851-1689 DHMH-16 Rav 1/89

TO THE HOSPITAL TO THE FUNERAL DE FILED WITHIN 72 H

DIVISION OF VITAL

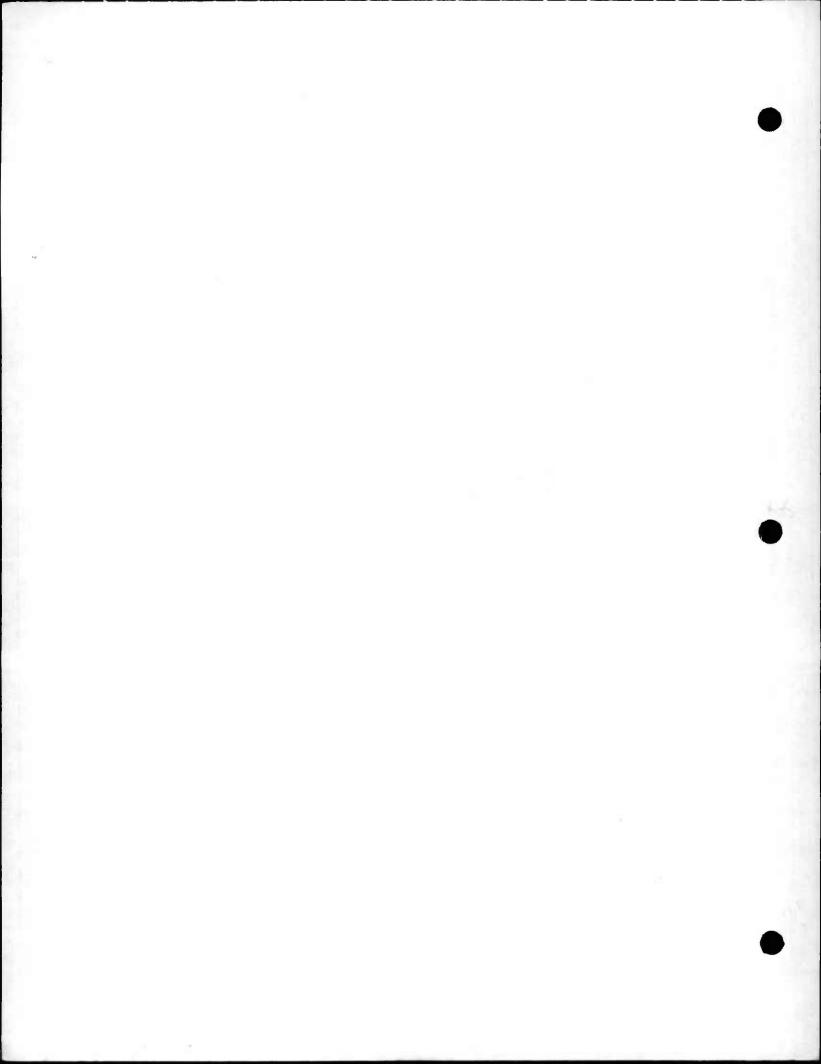
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OR ATTENDING PHYSICIAN:

HOSPITAL

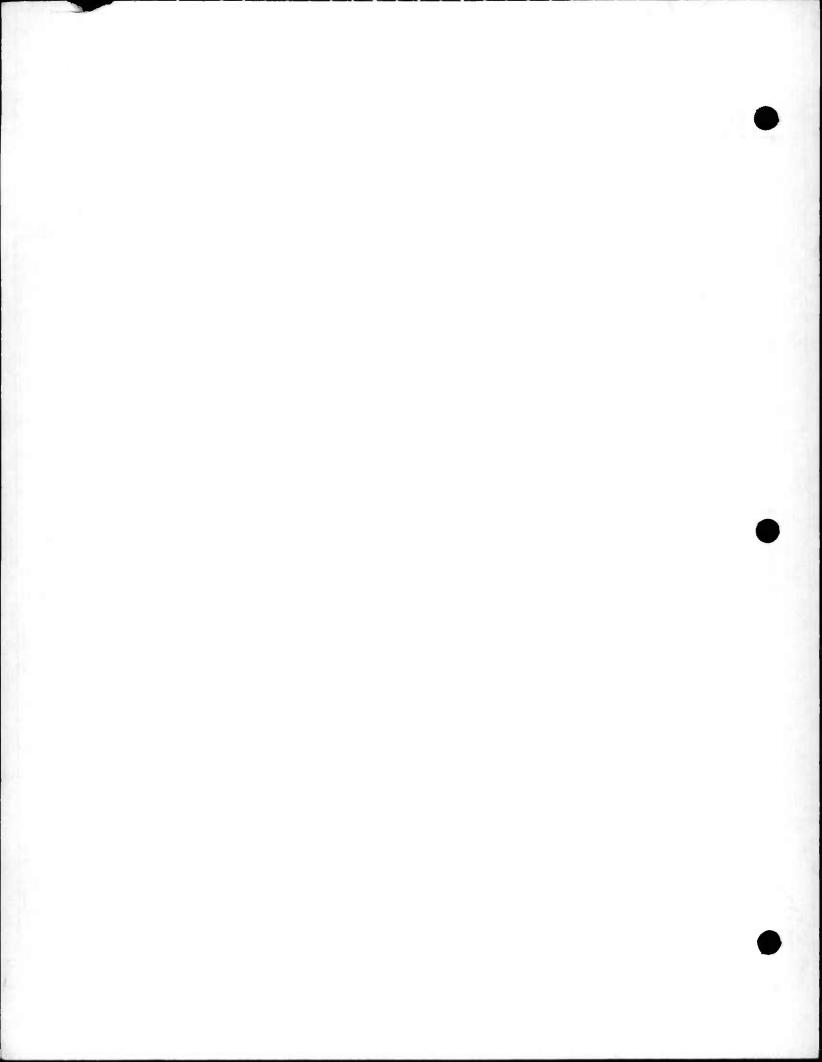
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician,	THE FUNETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit, Pages 1, 2, 3 should	De Tilled Within 72 hours affet death With the State Dept, of realth and Mental hygiene phor to burla, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires ti	TO THE FUNERAL DIRECTOR: After this certificate has been signed	De nied within 72 hours after death with the State Dept. of Health	IMPORTANT: If item 28 is marked, or item 23 shows at	

	1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTI			MENTAL	HYGIENI REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last) LENG Ka	te				2. DATE MONTH	OF DEATH	-	YEAR	3. TIME OF DE	
	213-74-0077	□ M 2XXF 100	MC MC	ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Month	OF BIRTH (Day, Year)		Country	PLACE (State or	Foreign
TOR	99. FACILITY NAME (If not institution, give street 14514 HOMECREST ROA RESIDENCE OF DECEMENT		9		VER SPRI			9c. COUNTY OF DEATH MONTGOMERY			
DIRECTOR	10a. STATE 10b. COUNTY MARYLAND MONTGO	MERY		OWN OR LOCAT			10d. INSIGE CIT LIMITS? 1 YES 2				
FUNERAL	100. STREET AND NUMBER 14514 HOMECREST ROA	D, #L-22		101.		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			7		
ВУ	11. MARITAL STATUS 12 1 Never Married 2 Merried 3 📉 Widowed 4 Divorced	S. ARMED X X NO S	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 ☐ YES 2(2ANO Specify:					14. RACE — American Indian, Black, White, etc. Specify: WHITE			
COMPLETED	15. DECEOENT'S EDUCATI (Specify only highest grade com Elementary/Secondary (0-12) 3	ON 184 opleted) 184 college (1-4 or 5 +)	e. DECEDENT'S US (Give kind of work life. Do NOT use re	done during mos stired.)	KIND OF BUS		STRY				
ME	17. FATHER'S NAME (First, Middle, Last)		HOME	MAKER				HOME			
	HYMAN TEICHMA	N			18. MOTHER'S NA						
BE	19e. INFORMANT'S NAME (Type/Print)		T 405 4444 HIG 40		YET		YAG				
5	PEARL LEVINE (DAUG		15101 1	NTERLA	CHEN DR.		2 SILVI	ER SP	RING		0906
	20e METHOD OF DISPOSITION 1 A Burlel 2 Cremation 3 A Removal 4 Donetion 5 Other (Specify)	From State Cornetted BE	TH DAVID	CEMET	ERY		17 ELM	ONT,	NEW	YORK	
	21. SIGNATURE OF BLANGRAL SERVICE LICENS	Thou	>	22. NAME AN DANZA 1170	D ADDRESS OF FA NSKY-GOL ROCKVILL	DBERGE PIK	MEMOI	RIAL	CHAP LE.	ELS, I	NC. 852
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. COVONANY HEART DISPASE XPAN XPAN										
CATION	Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (ON AS & CONSEQUENCE OF): LONG PSTIVE Heart Failure May leading to immediate cause. Enter UNDERLYING May leading to immediate cause.										
CERTIFICATION	c	DUE TO (OR AS A CO	NSEQUENCE OF):	7795							
EDICAL (PART II. Other significant conditions co	ontributing to death but n	not resulting in t	he underlying	cause given in		24s. WAS AN A PERFORM 1 YES 2	ED?		WERE AUTOPSY AVAILABLE PRIO COMPLETION OF DE DEATH?	R TO
ME	DID TORACCO LICE CONTRIBU	LITE TO CALLES OF F	SEATH VEC			_	•			1 - YES 2 -	NO
PHYSICIAN: M	DID TOBACCO USE CONTRIBUTION OF THE PROPERTY O		PLACE OF DEATH (UNCERTAIN	<u>и П Т</u>					
300	EXAMINER? HO	OSPITAL: Inpatient 2 ER/Outpatier	0	THER:	100						
¥	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME O		5 X Residence		(Specify) CRIBE HOW IN	IIIBA UCCII	DEO		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	M 1 Y		200. DE30	CRIBE NOW IN	JOHN OCCU	HED		
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — A building, etc. (Specify)	At home, farm, stree	et, factory, office		28f. LOCA City o	TION (Street en r Town, State)	d Number or	Rural Ro	ute Number,	
COMPLET		: To the best of my knowledge								end manner ee	stated.
									SIGN O		
TO BE	Hoong	J Pa	Ma		D 258	308		▶ 7	15	5/95	
-	30. NAME AND ADDRESS OF PERSON WHO CO	0	(ITEM 27) (Type, Prir		G.		A	1	21/4	PF SP	Mug
	STEPHONE S	22 MEGISTRAJES SIGNATUR	MD	10313	real	919	pro	-	rel	209	021
	JUL 18 1995	July d'holison	Mardall								



BOX 68760 DIVISION OF VITAL RECORDS, P.O.

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR CLARK MILLS KINNEY, JR. 1995 JULY 05 1:57 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign AUG. 12, 579-34-9169 68 MONTHS DAYS 1XXM 2 - F 1926 WASHINGTON, D.C. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give steet and number, WHITEHALL CREEK 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ANNE ARUNDEL RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY WASHINGTON, D.C. VES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4200 MASSACHUSETTS AVE. N.W. APT 403 the funeral director, page 5 should be detached for use as the burial-transit 20016 U.S.A. hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married specify Cuban, Mexican, Puerto Rican, etc.) В 3 Widowed 4 N Divorced 1 TYES 2 THE NO Specify: WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) PRESIDENT WIRE AND BELTING COMPANY once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) CLARK MILLS KINNEY, SR. Ħ ELDA EISINGER BE notified ; 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DOUGLAS S. KINNEY 851 ST. EDMONDS ST. ANNAPOLIS, MD. 21040 pe 20a. METHOD OF DISPOSITION

1 Burlal 2 Cremation 3 Removal from State 20c. LOCATION -- City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must DATE CONTACTOR OF THE CONTACT CONTA 4 ☐ Donetion 5 ☐ Other (Specify) 7/13 ROCKVILLE, MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS, INC lle elens 23. PAST I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, medicai and completely filled in by burial, cremation, or remo Approximata ehock, or heart feilure. Liet only pne ceuse pn each line intervel Between IMMEDIATE CAUSE (Finel Onset and Death the disease or condition resulting in death) DROWNING event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, 2 DUE TO (OR AS A CONSEQUENCE OF): the attending physician a Mental Hygiene prior to If any, leading to immediate the death certificate be cause. Enter UNDERLYING CAUSE (Disease or injury other that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 0 PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS Health and AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE that 1 ☐ YES 2 ☐ NO ALCOHOL CONSUMPTION 1 YES 2 NO t, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN CIAN has b Dept. 23 25. WAS CASE REFERRED TO MEDICAL The 26. PLACE OF DEATH (Check only one) certificate to the State HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: CREEK PHYSI 1 XYES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 6 Other (Specify) 4 Nursing Home 5 Residence þ 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED marked, PULLINE OF this (1 Natural 1:30 PM 7-5-95 FOUND 1 YES 2 NO SUBJECT DROWNED/UNKNOWN After t BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number City or Town, State) WHITEHALL CREEK 50 3 Suicide 6 XX Could not be ETED DIRECTOR: hours after 4 Homicide 28 FOUND: WATER ANNE ARUNDEL COUNTY, MD. Item COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DID BE filed within 72 hr (Check only one) HOSPITAL 2 MEDICAL EXAMINER: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 IIV 06 1995 CAUSE OF DEATH (ITEM 27) (Type, Print)

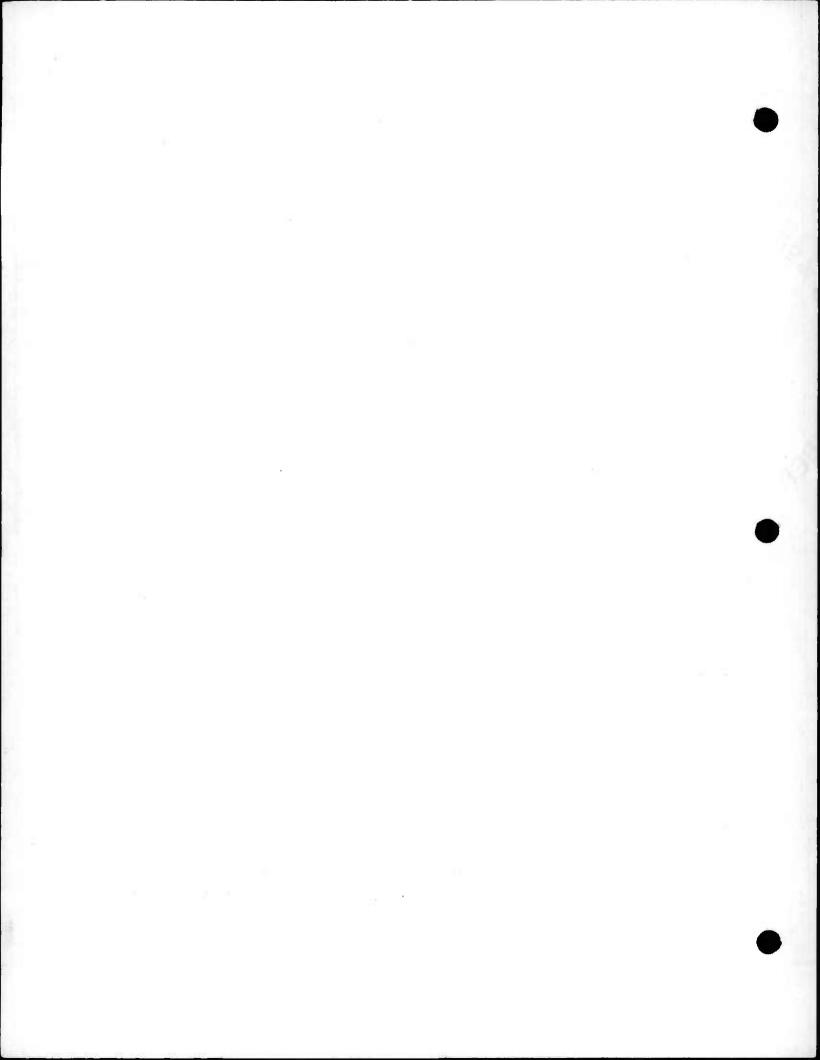
111 Penn Street, Baltimore, Maryland 21201

DOOR

712 31. DATE FILED (Month, Day, Year) lik.

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32. REGISTRAP'S SIGNATURE



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FUNERAL DIRECTOR: within 72 hours after

TO THE HOSPITAL OF THE FUNERAL OF BE filed within 72 ho HOSPITAL

7/17/95 MRT

ended #196 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First Middle I set) 2. DATE OF DEATH 3. TIME OF OEATH MONTH Agnes E. Ling 0310 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs ast birthday 7. DATE OF BIRTH (Month, Day, Year) June 25, IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 M 2 X F 577 46 4126 60 1935 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Brooke Grove Nursing Home Sandy Spring Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Rockville 1 YES 2 1 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 17025 Freedom Way 20853 United States 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 7 YES 2 5 NO 1 Never Married 2 Married IF YES, GIVE WAR OR DATES SpecMy: White 1 TYES 2 X NO Specify: BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ive kind of work done Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Computer Programmer Computer Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Aubrey Willett Mary E. Gamble BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 David E. King 10725 Freedom Way, Rockville, Maryland 20853 20a. METHOD OF DISPOSITION
1 Burlel 2 G Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) July 17, 1995 20c. LOCATION -- City or Town, State Commetery, cremetory or other place) July 1/, 1995 Montgomery Crematorium, Inc. 4 ☐ Donation 8 ☐ Other (Specify) Bethesda, Maryland 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery 21. SIGNATURE OF BUNERAL SERVICE Home/Rockville, Inc. M00689 Avenue, Rockville, Maryland 20850-2805 23. Part the diseases, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiec or respiratory errest, shock or haert feliure. List only one ceuse on aech line. Approximata Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition_ sepsis resulting in death) hours DUE TO (OR AS A CONSEQUENCE OF): possible aspiration procumonia CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING Progressive at DUE TO (OR AS A CONSEQUENCE OF): NY CAUSE (Disease or Injury thet initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE chronic obstructive pulmonary disease; severe steroid-induced osteoporosis; Pseudoxanthami PERFORMED? 1 TYES 2 NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES | NO | UNCERTAIN | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER:
Nursing Home 5 - Realdence 6 - Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. MANNER OF GEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 🔲 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) **BE** STAFF PHYSICIAN

18100 SladeSchool Rd. SandyS

WIPPLETEO CAUSE OF OEATH (ITEM 27) (Type, Print)

, 32. REGISTRAR'S SIGNATURE Alia Daviden Ro

Mary E. Gamble

10725 Freedom Way, Rockville, Maryland 20853

Montgomery Crematorium, Inc. Bethesda, Mary)
Home/Rockville, Inc. 300 West Mary
M00689 Avenue, Rockville, Maryland 20'

DIVISION OF VITAL RECORDS, P.O. BOX 131-6

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Temperal or attending physician.

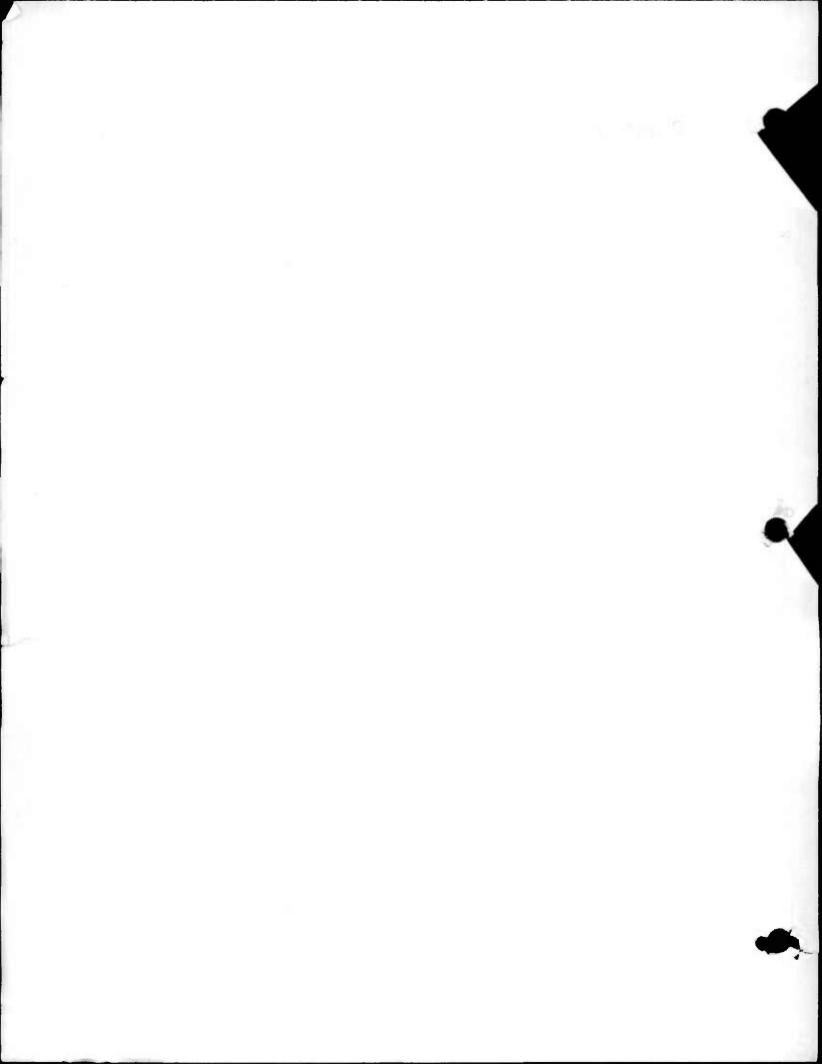
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunk-transit permit. Pages 1, 2, be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunk, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE	0F	MARYLAND	/ DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIENE
		C	ERTIFICATE	0	F DEAT	ГН		REG. NO.

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			IENTAL	HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH	,		TIME OF DEATH
	RAMCHAND 4. SOCIAL SECURITY NUMBER	RA K		CULKA UNDER 1 YEAR		JUL 7. DATE O	y 14		15	1 & 30 Au
	512-40-6829	1 M 2 - F 77		THS DAYS	HOURS MIN.	NOYE	mber	. "	Country)	
	9a. FACILITY NAME (If not institution, give a							7 India 9c. COUNTY OF DEATH		
DIRECTOR	Greater Laurel B	eltsville Ho	spital		Laurel			PRINCE GEORGES		
Ä.	10a. STATE 10b. COUNTY	Y	10c. CITY, TO	OWN OR LOCAT	ION				10	d. INSIDE CITY LIMITS?
		ce George's		В	eltsville	е				☐ YES 2 🛣 NO
FUNERAL	10e. STREET AND NUMBER			10t	ZIP COOE			10g. CITIZE	N OF WHA	T COUNTRY?
W.	4207 Brigg	s Chaney Road			2070					States
	1 Never Married 2 Merried	FORCES? 1 TYES	2 XX10	II yes, spi	ENDENT OF HISPANI celfy Cuben, Mexicen	, Puerto R		or No — 1	Black, W	American Indian, /hite, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	NES	I L TES	2 NO Specify:				Specify:	Asian
9	15. DECEDENT'S EDU (Specify only highest grade		18e. DECEDENT'S USI			16b.	KIND OF BUS	INESS/INDUS	STRY	
9	Elementary/Secondery (0-12)	College (1-4 or 5+)	Ilfe. Do NOT use re	tired.)			rivațe			
COMPLETED		5+	Organic (hemist					S GOV	vernment
	17. FATHER'S NAME (First, Middle, Last)	3			18. MOTHER'S NAM					
BE	Kris 19e, INFORMANT'S NAME (Type/Print)	hna Kulkarni	19h MAII ING AD	DRESS (Street II	nd Number or Rural R		pa Gub		Corde)	
2	Vijay Kulkar	ni			on Drive					20854
	20a. METHOD OF OISPOSITION 1 ☐ Burlel 2 Å Cremetion 3 ☐ Rem							CATION — CI		
	1 Buriel 2 \(\text{Discrete} \) Cremetion 3 \(\text{Rem} \) Rem 4 \(\text{Discrete} \) Donation 6 \(\text{Discrete} \) Other (Specify)	oval from State	other place) Ju Montgomers	Crema	torium I	nc.	Bet	hesda	, Mai	ryland
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		22 NAME AN	D ADDRESS OF FAC	bhre	v Fune	ral H	ome/	Wisconsin
	Down 9	K. Short	M00335	Bethe	sda-Chev e Bethes	y Ch	ase, I Maryla	nc. 7	557 \ 814-3	Wisconsin 3501
	23. PART I. Enter the diseases Dr	complications that coused	tha death. Do not							Approximate
	IMMEDIATE CAUSE (Final	List only one cause on e	ach ilne.							Interval Between Onset and Death
		MYDCARD	IAL INF	ARCTI	(AC)				WK	
ı										
2	Sequentially list conditions,	b. CORONARY DUE TO (OR ALA	ARTERY D	isease						years
Ě										LIO LO C
윤	CAUSE (Disesse or injury that initiated events	c. Hyperten	CONSEQUENCE OF):					grans		
CERTIFICATION	resulting in death) LAST	. Dishetes 1	Mellitus							years
	PART II. Other significent condition			he underlyin	Part i	24s. WAS AN	ALITOPEV	ERE AUTOPSY FINDINGS		
CAL	TAIT II. GIRLS SIGNISSIN CONDITION	- Continuently to destin b	dt not resulting in i	ine underlyin	g couse given in i		PERFOR	MED?	AV	MILABLE PRIOR TO OMPLETION OF CAUSE
		<u> </u>				-	1 TES 2	□X NO	OI	F DEATH?
						- 1			'	YES 2 NO
PHYSICIAN: MEDI	25. WAS CASE REFERRED TO MEDICAL			26. P	ACE OF DEATH (Che	ock only on	10)			
Sic	EXAMINER? 1 X YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Out		THER:	e 5 XResidence	6 🗆 Othe	r (Specify)			
E	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME C	F 28c. IN.	URY AT	28d. OES	CRIBE HOW I	NJURY OCCL	JREO	
BY	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆	_					
	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, etc. (Spe	r — At home, farm, atre	et, factory, offic	•		ATION (Street or Town, State)		v Rural Rou	te Number,
	290. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my know	dedoe death occurred	et the time date	and place, and due	to the cou	see(e) and mar	oner en eleter	d	
COMPLETED	(Check only one) 2 MEDICAL EXAMIN							nd manner as stated.		
	29b. SIGNATURE AND TITLE OF CERTIFIE	ER .			29c. LICENSE NUM	ABER		29d. DATE	SIGNED (M	fonth, Day, Year)
O BE	Serger MD	>			D259	25		29d. DATE SIGNED (Month), Day, Year) Tuly 14, 1995 4, Md Z0814		
5	J.M. BERGER	HO COMPLETED CAUSE OF OF	T720 WIL	ine) SCONLS/	JAve,	ВеТн	esda,	md	20	814
	31. OATE FILEO (Month, Day, Year)	82. REGISTRAR'S SIGN	IATURE					•		





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TO THE HOSPITAL DRATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examinar must be autition at the contribution.

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	1 - FOR STATE REGISTRAR		STATE OF I	MARYLAND C	/ DEPAR	RTMEN	T OF H	IEALTH DEA	AND I	MENT	AL HYGIEN	_		
	1. DECEDENT'S NAME (Fin	st, Middle, Lest,)								E OF DEATH		3	. TIME OF DEATH
	Lothar		K	utsche	r					JII	Ty 7,	1995	YEAR	9:15 A m
	4. SOCIAL SECURITY NUM	ABER .	5. SEX	. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF				IF UNDER	R 24 HRS.	7. DAT	E OF BIRTH	1	8. BIRTHPL	ACF (State or Foreign
	077_ 36-1	1395	1 XM 2 - F	7 3	YRS.	MONTHS	DAYS	HOURS	MIN.	Jun	e 9, 1	922	Country)	stria
	9e, FACILITY NAME (If not		street end number)			9b. CIT	Y, TOWN C	OR LOCATI	ON OF DE				ITY OF DEA	
1 5	Hebrew Ho	ome of	Greater	Washing	ton	Roo	ckvi:	lle					gomery	
Ĕ	RESIDENCE OF DE	CEDENT									110.			31
DIRECTOR	10e. STATE	10b. COUN			10c. CIT		OR LOCAT						10	Dd. INSIDE CITY LIMITS?
	Md.		ontgomery			RO	ckvi:	rre					1	YES 2 NO
FUNERAL	104. STREET AND NUMBER	R					101	ZIP COD	_			10g. CITI	ZEN OF WH	AT COUNTRY?
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	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. A	EVER IN U.S. ARMED 13. WAS DECENOE It yes, specify				OF HISPAN	HC ORIG	IN? (Specify Yes	or No-	14. RACE -	- American Indian, Vhite, etc.
ΒYΙ	1 Never Married 2 3 Wildowed 4 Div		IF YES, GIVE Y	AR OR DATES	440		1 YES	2 NO	Specify	n, Puerto /:	Ricen, etc.)		Specify:	
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COMPLETED	(Specify or	CEOENT'S EDI	UCATION le completed)	(0	ECEDENT'S Bive kind of	work done	during mo	ON ast of workli	ng	16	b. KIND OF BU	SINESS/IND	USTRY	
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함	12				Owner	<u> </u>				_	Restau		Night	Club
at once	17. FATHER'S NAME (First,	Middle, Last)									Middle, Meiden	Sumame)		
B B	Unknown								nknov					
TO BE	196. INF-UHMANT 'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
ē _	Samuel Rosenkrantz 8305 Haddon Dr. Takoma Park, Md. 20852 200. METHOD OF DISPOSITION DATE 200. LOCATION - City of Town, State													
must be	20e. METHOD OF DISPOSI 1 □ Burlel 2 ☑ Cremat	TION Ion 3 🗆 Rer	noval from State	20b. PLACE cemetery, cn				me of		DA	TE 20c. LO	CATION —	City or Town	, State
	4 Donation 5 Othe	4 Donation 5 Other (Specific Alexandria, Va. 21. SIGNATURE OF FUNERAL SERVICE UCENSEE 22. NAME AND ADDRESS OF FACILITY												
	21. SIGNATURE OF FUNER	AL SERVICE L	CENSEE		-						1 D			
	12/1	11					tawa) 1091	ra Sa Roci	agei.	run le F	eral D	ırect ckvi l	le. N	rd. 20852
2	Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate													
9	interval Between													
Ē	IMMEDIATE CAUSE (Fi	mai		2.6										Onset and Dasth
event, the medical examiner	resulting in death)		s. Acute	MYOCAT	CIAL OF O	Int	arct					-		24 Hours
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	cause. Enter UNDERLY	ING				,-								İ
	CAUSE (Disease or Injustration initiated events	ury	DUE TO	OR AS A CONSE	QUENCE O	F):								
ERTIFICATION	resulting in death) LAS	ST	4											
- 45		d												
AL C	PART II. Other signific	ant conditio	ns contributing to	daath but not	resulting	in the u	ndarlying	cause (given in i	Part I.	24s. WAS AN PERFOR			ERE AUTOPSY FINDINGS
MEDICAL											1 YES 2		CC	MPLETION OF CAUSE DEATH?
M M														YES 2 NO
	DID TOBACCO U	JSE CONT	RIBUTE TO CA	USE OF DEA	TH YE	S 🗆	NO E	UNC	ERTAIN	1 🗆	1			-
M M	25. WAS CASE REFERRED EXAMINER?	TO MEDICAL		28. PLA	CE OF DEAT	TH (Check	only one)							-
2	1 TYES 2 XNO		HOSPITAL:	ER/Outpatient 3	□ DOA	4 XNu		e 5 🗆 Re	sidence i	8 🗆 Oth	et (Specify)			
PHYSICIAN:	27. MANNER OF OEATH		28e. OATE OF (Month, Di		28b. TIM	E OF URY	28c. INJU	URY AT		28d. DE	SCRIBE HOW II	NJURY OCC	URED	
BY	1 XNatural 5 2 Accident	Pending Investigation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,	""	M	_	ES 2] NO					
	3 Suicide 8	Could not be	28e. PLACE Of building.	F INJURY — At he	ome, farm, s	street, fac	tory, office			28t. LO	CATION (Street e	nd Number	or Rural Rout	e Number,
2 E	4 Homicide	determined	195-5-4							Olij	or Town, State)			
COMPLET	29e. CERTIFIER (Check only	TIFYING PHYS	ICIAN: To the best of	my knowledge, de	ath occurre	d at the t	time, date	end place.	and due	to the ca	use(e) end men	ner ee state	d,	
WO			ER: On the basie of ex											nd menner es stated.
E C	296. SIGNATURE AND JTD.								NSE NUM					onth, Day, Year)
8	101/15	0,0	1. 200	++~~~24	~ 171	roi -								
= 은	30 NAME AND ADDRESS O	F PERIODE N	O COMPLETED CAUS	ttendin	u Pn	SIC	ıan	חדמנ	704	_			/8/95)

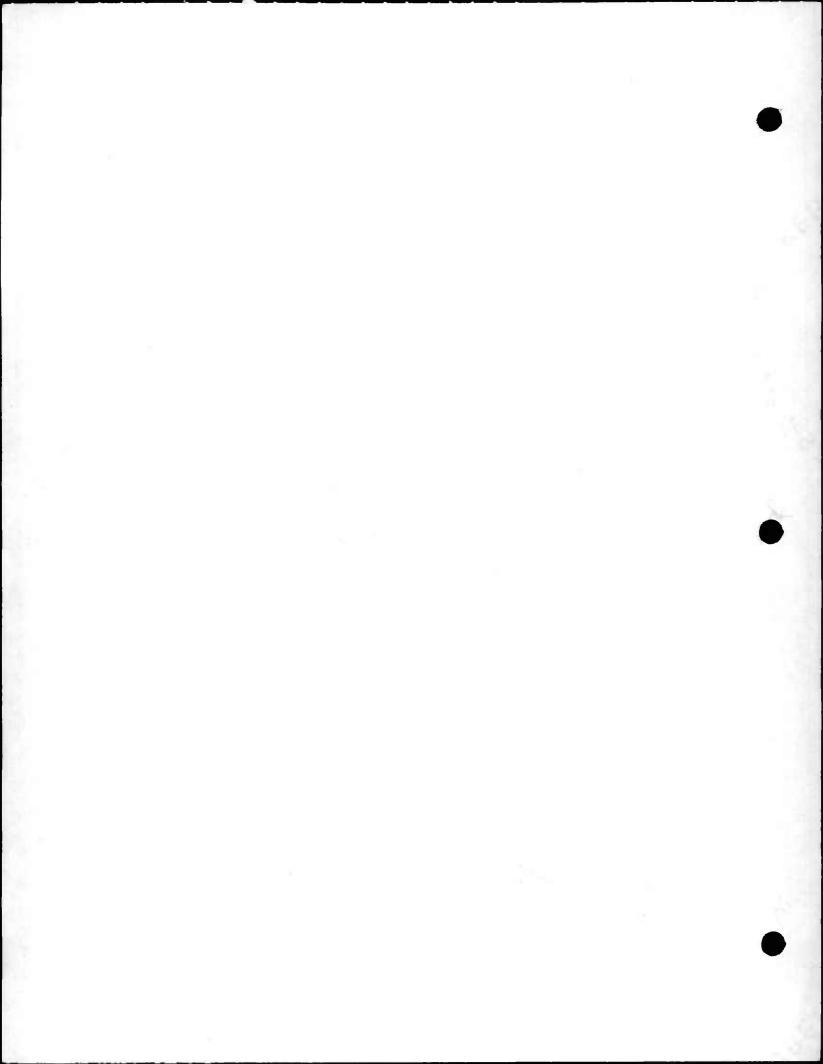
Attending Physician
HO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S SIGNATURE

MD 6121 Montrose Rd. Rockville, Md.20852

D. Patel,
31. DATE FILED (Month, Day, Year)

JUL 17 1995



ALTIMORE, MARYLAND 21215-0020	death Dress & ways he pathiand he she honeign as assenting at airing
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

G PHYS	After this certificate has been signed by the attending physician	with	f Nem 28 is marked, or Nem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PH	TO THE FUNERAL DIRECTOR: After the	be filed within 72 hours after death w	IMPORTANT: If Item 28 is marked

												95	2	3375
	1 - FOR STATE REGISTRAR		STATE OF I	MARYLAND /		RTMENT				MENTA	L HYGIEN	_		
Î	1. DECEDENT'S NAME (First	, Middle, Last)	-								E OF DEATH			3. TIME OF DEATH
	Mo	era	aret	4	22	X	ei	ste		MON	TH (_ DA	"iS	YEAR	10007
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH	18		HPLACE (State or Foreign
	214-28-6871		1 M 2 7 F			MONTHS	DAYS			7. DATE OF BIRTH/ (Month, Day, Year)		,	Coun	itry)
- 6	9e. FACILITY NAME (If not in	and the state of the state of		00							. 16,1	V		yland
~				"-				R LOCATI				9c. COL	JNTY OF	DEATH
0			e World	Blvd. #3A Silver Spring							- 0	Mont	gomery	
DIRECTOR	RESIDENCE OF DEC	10b. COUNT	~	10c, CITY, TOWN OR LOCATION					-					
E	122 122 1	Total design			10c. C11	.,								10d. INSIDE CITY LIMITS?
	Maryland	M	lontgomer	У			Silv	er S	prin	ıg				1 TYES 2 XNO
₹	10e. STREET AND NUMBER						101	. ZIP COD	E			10g. CIT	IZEN OF	WHAT COUNTRY?
FUNERAL	3311 South	Leisur	e World	Blvd., #	3A			209	06			Uni	ted	States
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AR	MED	13.	WAS DEC	ENDENT C	F HISPAN	VIC ORIGI	N? (Specify Yee		14. RAC	E - American Indian.
	1 Never Married 2		FORCES? 1	YES 2	10		If yes, sp	2 K NO	n, Mexica	n, Puerto	Rican, etc.)		Blec	ck, White, atc.
В	3 X Widowed 4 Divo	rced	1 120, 0.12	AN ON DATES			1 1 123	2 W	Specin	γ:			Spec	White
	15. DEC	18e, DE	CEDENT'S	USUAL O	CCUPATIO)N		16	b. KIND OF BUS	INFEC/IN	DUSTRY	WILLE		
E	(Specify only Elementary/Secondary (C	(G	ive kind of	work done	during mo	at of working	ng	"	o. Killo of boo	PHILESON 119	DOSTRI			
7	12	·) [ata	Proc	9660	r			County	GOVA	rnme	nt		
COMPLETED					ucu	1100				_			Timile	:110
8	17. FATHER'S NAME (First, M		2 2 2					18. MOTI	2.5		Middle, Maiden	,		
BE			Arnold			_			Mar	gare	et Reed			
2	19e. INFORMANT'S NAME (7	ype/Print)									nber, City or Town			
-	Barbara A.	Keesec	ker	4	26 B	elvi	ew A	venu	e, H	ager	stown,	Mar	ylan	d 21742
- 1														
	206. METHOD OF DISPOSITION X Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 21, 1995) 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State Frostburg Memorial Park Frostburg, Maryland													
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral													
	\mathcal{L}	. (He	ome/	Rock	vill	e, I	nc., 3	00 W	. Mo	ntgomery Av
	Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805													
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,													
- 1	shock, or hasrt failure. List only one cause on each line. IMMEDIATE CAUSE (Final													
	disease or condition			7.4	er.	05	(0		Hear	4	20	
	resulting in death)		S. DUE TO	(OR AS A CONSEC				E 0 E			aproce		22 3	and the
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RTIFICATION	Sequentially list conditi		b	(OR AS A CONSEC	DUENCE O	F)·				-				
A	if any, lasding to immed cause. Entar UNDERLY			,		,								İ
유	CAUSE (Disesse or inju		C	(OR AS A CONSEC	NIENCE O	ο.								
Ē	that initiated events resulting in death) LAS		502 10	(ON AS A CONSE	DOENCE O	r).								i
50	== 1.010 = 10pm		d,											
9	PART II. Other significa	nt condition	s contributing to	daath but not r	esultino	in the un	derlying	1 Causa c	iven in	Part i	24a. WAS AN	ALITODEV	1 241	. WERE AUTOPSY FINDINGS
MEDICAL							,			, and it	PERFOR		246	AVAILABLE PRIOR TO
ā										_	1 YES 2	NO		COMPLETION OF CAUSE OF DEATH?
≝														1 TYES 2 NO
ž I	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE OF DEA	TH YE	S 🔲 1	10 C	UNC	ERTAIN	V 🗆				
<u></u> ₹	25. WAS CASE REFERRED TO	MEDICAL		28. PLAC	E OF DEA	TH (Check	only one)							
ဗ ျ	EXAMINER?		HOSPITAL: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	□ DOA	OTHER		. 2/2	aldeas		er (Specify)			
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF		28b. TIM		28c. INJ		skience		SCRIBE HOW IN	I II IBY OC	CHBED	
	1 Netural 5	Pending	(Month, D			URY	WO	RK?	100	200. DE	SCHIBE HOW II	SONT OC	COMED	
à l	2 Accident	Investigation	20. 51.107.5	F IN HIPM	L			'ES 2 [) NO					
9		Could not be determined	zee. PLACE O building,	F INJURY — Af ho atc. (Specify)	me, ferm,	etreet, fact	ory, office			281. LOC City	CATION (Street a or Town, State)	nd Numbe	r or Rural	Route Number,
-	- Indiana													
7	29e. CERTIFIER (Check only	IFYING PHYS	CIAN: To the best of	my knowledge, de	ath occurr	ed at the ti	me, date	end place.	end due	to the ce	use(e) end man	ner ee ste	(led,	
COMPLE														e) end manner ee stated.
ا ا					111		1000							
H	296. SIGNATURE AND TITLE	OF CEHTIFIE			1 - C			29c. LICE	NSE NUM	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
2	050		لاسل د		an	۷		البد	08	2	46		San	18-91
- 1	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS	SE OF DEATH (ITE	4 27) (Type	Print)						-	> >	

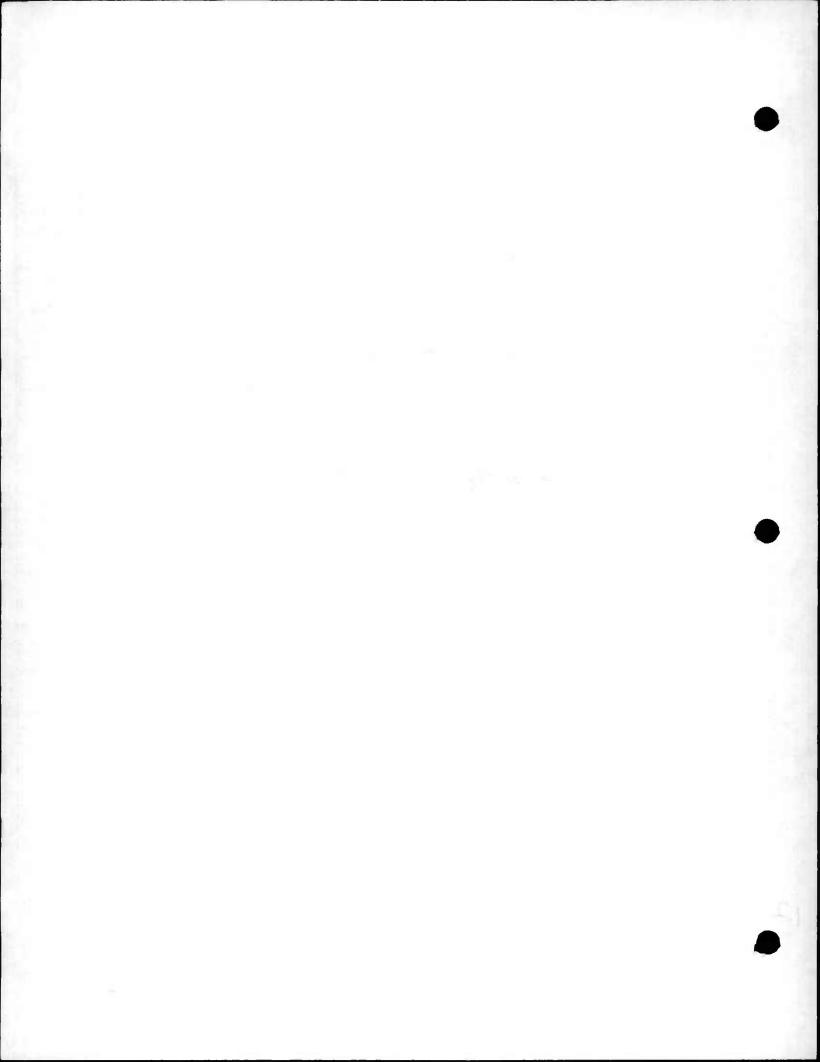
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo. Print)

31. DATE FILED (Morrit, Day, Voar)

JUL 20 1995

PRESISTRAT'S SIGNATURE

JUL 20 1995



	1 - FOR STATE REGISTRAR		STATE OF	MARYL	AND /	DEPAR	RTMENT	OF I	HEALTH	AND	MEN	NTAL HYGIEN				
	1. DECEDENT'S NAME (First	, Middle, Last)			_						2.1	DATE OF DEATH			3. TIME OF DE	ATH
	EARL	FRAN	KLIN LAMB								j	ULY 1	9 1	995	4:00	D M
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE	(In yrs. las	t birthday)	IF UNDER	1 YEAR	IF UNDER	9 24 HRS.	7. 0	DATE OF BIRTH		8. BIRTI	HPLACE (State or	Foreign
	228-26-747	78	1 🔯 M 2 🗌 F		69	YRS.	MONTHS	DAYS	HOURS	MIN.	N	(Morth, Day, Year) Nov. 28, 1925			Virginia	
	9e. FACILITY NAME (If not in	stitution, give	street end number)				9b. CITY	TOWN	OR LOCATI	ON OF O		01.20,13		NTY OF E		
DIRECTOR	Washington	n Adve	ntist Ho	spit	a1	Takoma Park								mery		
	10a. STATE	10b. COUNT				10c. CIT	Y, TOWN C	R LOCA	TION	ON .					10d. INSIDE CI	TY
1 8	Maryland	Pri	nce Geor	res		н	yatts	svil	1e				Limit			
1 1	10a. STREET AND NUMBER			500			,		r. ZIP COD	E			10a CIT	176N OF 1	1 X YES 2 (
FUNERAL	3915 Ogleth	norna	Stroot					"		_	78	2	log. Cit	IZEN OF		,
Z	11. MARITAL STATUS	lorpe	12. WAS DECEDEN	IT EVED I	MII C AD	MED	1 42 1	AM C DE	CENDENT			RIGIN? (Specify Yes			USA	
	1 Never Married 2 🔀	Married	FORCES?	X YES	2 N	10	- -	f yes, sp	ecify Cube	ιπ, Mexica	an, Pu	erto Ricen, etc.)	or No-	14. RACI	E — American In k, White, etc.	dlen,
B	3 Widowed 4 Divo	rced	IF YES, GIVE	WWII	DATES		1	YES	2 🔯 NO	Specif	ly:			Spec	"y: White	2
8	15. OEC	EDENT'S EOL	CATION		16e, DE	CEOENT'S	USUAL O	CUPATI	ON			16b. KIND OF BU	SINESS/INI	HISTRY		
(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.)									311123371111	Josini						
15. OECEDENT'S EQUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Television 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Repairman Television 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname)																
8	17. FATHER'S NAME (First, M	liddle, Last)			INC	Pail	man		18 MOTI	HED'S NA	ME /S	First, Middle, Maiden		11		
	Champ Y. La											Estelle	,	0.77		
H	190. INFORMANT'S NAME (7				100	MAILING	ADDRESS	/C+				Number, City or Tow				
임															2.0	
	Earl F. Lar					-				, hu		ingtown,		206		
	1 Suriel 2 Cremation 4 Donation 6 Other	on 3 🗆 Ren	noval from State	cen	gate Gate	matory-or o	of Dispos ther place) Heave	en C	eme of Cemet	ery	7/	0ATE 20c. LO 22/95 S			ring, M	D
	22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901															
	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line.															
	shock, or he iMMEDIATE CAUSE (Fin	eert lallure.	List only one car	use on e	ech iine				-	D					Interval	Between nd Death
	disesse or condition	THE STATE OF THE S	~	m	1	4	1 10		?	L		D.			Offiset at	id Death
1	resulting in death)		e. Due to	(OR AS	A CONSEC	UENCE O	Ev /		\(\)	1 7	A	lion	~		41	W Z
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CERTIFICATION	Sequentially list conditi		ove ro	(OR AS	A CONSEC	UENCE O	PI:		1						4-4	ulk,
¥	if any, leading to immed cause. Enter UNDERLY	ING	U				,								İ	
E	CAUSE (Diseese or inju that initiated events	iry	DUE TO	(OR AS A	CONSEC	UENCE O	F):									
E	resulting in death) LAS	7														
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AL.	PART II. Other significa	nt condition	ne contributing to	death b	out not n	esulting	in the un	deriyin	g cause o	given in	Part	i. 24a. WAS AN PERFOR		24b	WERE AUTOPSY	
EDIC												1 YES 2			COMPLETION OF	
WE															1 YES 2	(NO
ž	DID TOBACCO U	SE CONT	RIBUTE TO CA	USE C	F DEA	TH YE	S 🗆 N	10 E	JUNC	ERTAIN	N	g/				
ΜĂ	25. WAS CASE REFERRED TO						TH (Check o				7	<u> </u>				
PHYSICIA	EXAMINER?		HOSPITAL:	ER/Out	patient 3	□ ĐOA	OTHER 4 Num		10 5 □ Ro	eldence	• 🗇	Other (Specify)				
	27. MANNER OF DEATH		28e. DATE OF	INJURY		26b. TIM	E OF	28c. INJ	JURY AT	ardeline.	_	DESCRIBE HOW I	NJURY OC	CURED		
		Pending	(Month, E	lay, Ybar)		INJ	URY	WC	PRK?	¬ NO		100 200				
В	a C a	Investigation	28e. PLACE C	F INJURY	′ — At ho	ne, ferm.	street, facto			10.7	281	LOCATION (Street a	and Number	or Pural 6	Bouto Alumbar	
8		Could not be determined	building,	etc. (Spec	cify)			,,				City or Town, State)	I THE PERSON	Un righted P	TOUTO TTUITION,	
MPLET	29e. CERTIFIER	newspect in	///	, ,		-			-		_		-			
MP	(Check only		ICIAN: To the beat of													
2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occured at the time, date and place, end d								d due to th	e ceuse(e	end manner ee	stated.					
W 296. SIGNATURE AND TITLE OF DERTIFIER 29c. LICENSE NUMBER										29d, DAT	E SIGNED	(Month, Day You	9			
0	Dans	21 20	lister	J.M	DF	AC+)		D	119	2	9	D 7	119	145	
유	30. NAME AND APORESS OF	PERSON WH	O COMPLETEO CALL	SE DE DE	ATH /ITEA	1 27) / Turne	Drint)				-	1			+	

CAUSE OF DEATH (ITEM 27) (Type, Print)

2 7610 CARROLL

SCR 7610

32. REGISTRAR'S SIGNATURE

A DAWGLON RANGE

DAVID TS. KESSCER
31. DATE FILED (Month, Day, Yber)

JUL 21 1995

JUL 21 1995

ment director, page 5 should be detached for use as the burial-transit

Pages 1, 2, 3 should

permit.

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DIVISION OF VITAL RECORDS, P.O. BOA 88784	_	-	Ĕ	==
	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after d	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical a
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH PEGGY 995 MADSEN EWIS TUCY 12:44 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year)
Oct. 26, IF UNDER 1 YEAR 228-40-2913 1 M 2 T F DAYS HOURS 64 1930 Virginia 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PRINCE GEORGE'S Doctor's Hospital Lanham RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Marvland Prince George's College Park 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7519 Creighton Drive 20740 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puarto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most clife. Do NOT use retired.) 16h KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Montgomery Co. School System 3 Secretary once. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) James Madsen BE Annie Dell notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Anne C. Robling Creighton Drive, College Park, Maryland 20740 pe 20s. METHOD OF DISPOSITION
1 🖾 Buriel 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Must Genetery cremetory or other place)
George Washington Cemetery 7/13 Adelphi, Maryland 21. SIGNATURE OF FUNERAL SERVICE LADWINGER 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximata shock, or heart failure. List only one causa on each lina. Interval Between IMMEDIATE CAUSE (Final **Onaet and Daath** the disease or condition VENTRICULAR FIBRILLATION
DUE TO (OR AS A CONSEQUENCE OF): resulting in death) al hR event. VENTRICULAR TACHY CARDIA, EPISODIC
DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION traumatic Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 Injury. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO shows any COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item HOSPITAL: HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 50 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 3 Sulcide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 Is ED 8 Could not be 4 Homicide COMPLET 29a. CERTIFIER CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER DB 5925 29d. DATE SIGNED (Month. Day, Year, BE * Beryon MD 9

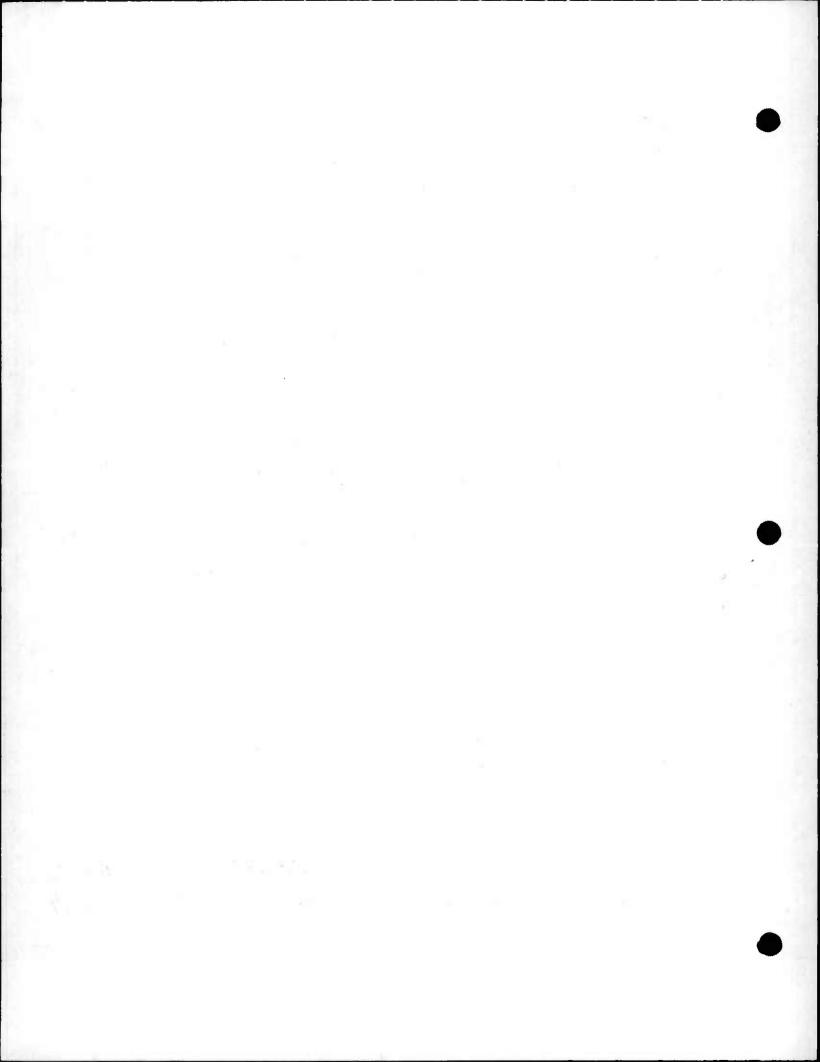
J. BERGER MD #205,7720 WISCONSINAVE, Be. Mesda, Md 208

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

lia Davidson Revolate

1995

31. DATE FILED (Month, Day, Mar)



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or atter	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use a	27	
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	-11	FOR STATE REGISTRAR		STATE OF I	MARYLAND /			NT DF H				HYGIEN REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, Last)									2. DATE OF	DEATH			3. TIME OF DEATH
		Eva B. Levine									July 19, 1995				3:45 A M
		4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. les	t birthday)		ER 1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF	BIRTH	199.	8. BIRTH	PLACE (State or Foreign
ı	1	104-18-3400		1 🗌 M 2 🖳 💢 F	71	YRS.	MONTH	DAYB	HOURS	MIN.	(Month, L		, 10	Countr 23	New York
	ţ	9a. FACILITY NAME (If not institution, give street and number)					9b. Cl	TY, TOWN (OR LOCATI	ON OF DE		st 17		NTY OF D	
8	15115 Interlachen Dr. Apt.#1022 Silver Spring							ng		M	lontg	omery			
DIRECTOR		RESIDENCE OF DECEDENT								-					
1 2				10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?					
	- 8	Md. Montgomery Silver Spring								1 X YES 2 NO					
₹	10e. STREET AND NUMBER 10f. ZIP CODE											VHAT COUNTRY?			
FUNERAL		15115 Interlachen Dr. Apt.											US	A	
5		11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEOENT EVE FORCES? 1 Y					13. WAS DECENDENT OF HISPAN 11 yes, specify Cuban, Maxican			IIC ORIGIN? (Specify Yes or No- n, Puerto Ricen, etc.)		or No-	- 14. RACE - American Indian, Black, White, atc.		
ĕ	1	3 Widowed 4 Divo		IF YES, GIVE V	MAR OR DATES		1 TES 2 NO Specify						Specify: White		
Ü		15. DEC	EDENT'S EDU	CATION	18a. OF	CEDENT'S	IAUSU	OCCUPATIO	ON.		105 1/2	NO OF BUE	1	MINTEN	
E E		(Specify onl	ly highest grade	completed) College (1-4 or 5	(G	MECEDENT'S USUAL OCCUPATION (Rive kind of work done during most of working fe. Do NOT use retired.)					JUSTAT				
ᆜᆸ		12	0-12)	College (1-4 or 5	*/	mer						Liquo	r		
COMPLET		17. FATHER'S NAME (First, M	Aiddle, Last)						18. MOT	HER'S NAI				-	
E G		16. MOTHER'S NAME (First, Middle, Last) Samuel Brody Anna Mudrick Brody													
g 0	Н	19a. INFORMANT'S NAME (7	Type/Print)		191	b. MAILING	ADDRE	SS (Street a						Code)	
2		196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11404 Cephise Ct. Gaithersburg, Md. 20878													
20		20a, METHOD OF DISPOSITION 20b, PLACE AND DATE OF DISPOSITION / Name of OATE 20c LOCATION - Clfv of Town State													
Ĕ		1 & Burlet 2 Cremation 3 Ramovet from State 205. PLACE AND DATE OF DISPOSITION (Name of aggregatery, cremation of plants place) A Donation 5 Other (Specify) A David Memorial Cemetery 7/21 Falls Church, Va.													
examiner	M	21. SIGNATURE OF FUNERAL SERVICE LIGHDING 22. NAME AND ADDRESS OF FACILITY													
Edward Sagel Funeral Direction 1091 Rockville Pike Rockville,									ion	MA 20052					
	1	23 PART I Finer the diseases or complications that covered the death Decate the death													
Bedica		snock, or neart reture. List only one cause on each line.													
	IMMEDIATE CAUSE (Final									Onset and Death					
event, the		disease or condition resulting in death) a. Aspiration Pnemonia Day 5 DUE TO (OR AS A CONSEQUENCE OF):													
		Do to form as a consequence of the													
y, or other traumatic CERTIFICATION	ł	Sequentially list conditions, If any, leading to immediate Due to lon as a consequence of: Due to lon as a consequence of: Tegran Survey of the sequence of													
X In	ı	cause. Enter UNDERLYING													
TIFICATION	1	CAUSE (Disease or Injury that Initiated events OUE TO (OR AS A CONSEQUENCE OF):													
F F		resulting in death) LAST													
	ı	PART it. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY FINDINGS													
A I	ı	PART IC Other algoritica	condition	contributing to	death but not r	aaulting	in the u	ındariying	causa g	given in i	Part I. 24	PERFORE		24b.	WERE AUTOPSY FINDINGS WAILABLE PRIOR TO
		LOVE 18 MAN								COMPLETION OF CAUSE OF DEATH?					
: MEDIC													,		1 TES 2 NO
S N		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN													
E C		25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:													
YS.	1	1 YES 2 NO		1 - Inpatient 2 -		□ DOA	4 - Nu	raing Hom	5 X R	sidenca (6 🗆 Other (S	pecify)			
BY PHYSICIAN: MEDICA		27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28d. OESCRIBE HOW INJURY OCCURED													
<u>∞</u> 0		3 Suicide 8 Could not be datarmined 28s. PLACE OF INJURY — At home, tarm, street, factory, office 5city or Town, State) 28s. LOCATION (Street and Number or Richts City or Town, State)							or Rural Ru	oute Number,					
		29s. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.													
COMPLETE															and manner as stated.
- 1	1	296. SIGNATURE AND TITLE					-								
	Ī	10.000	The same of the sa	-	_		_		ANC. LICE	NSE NUM	NAC 7		29d. DATE	SIGNED	(Month, Day, Year)

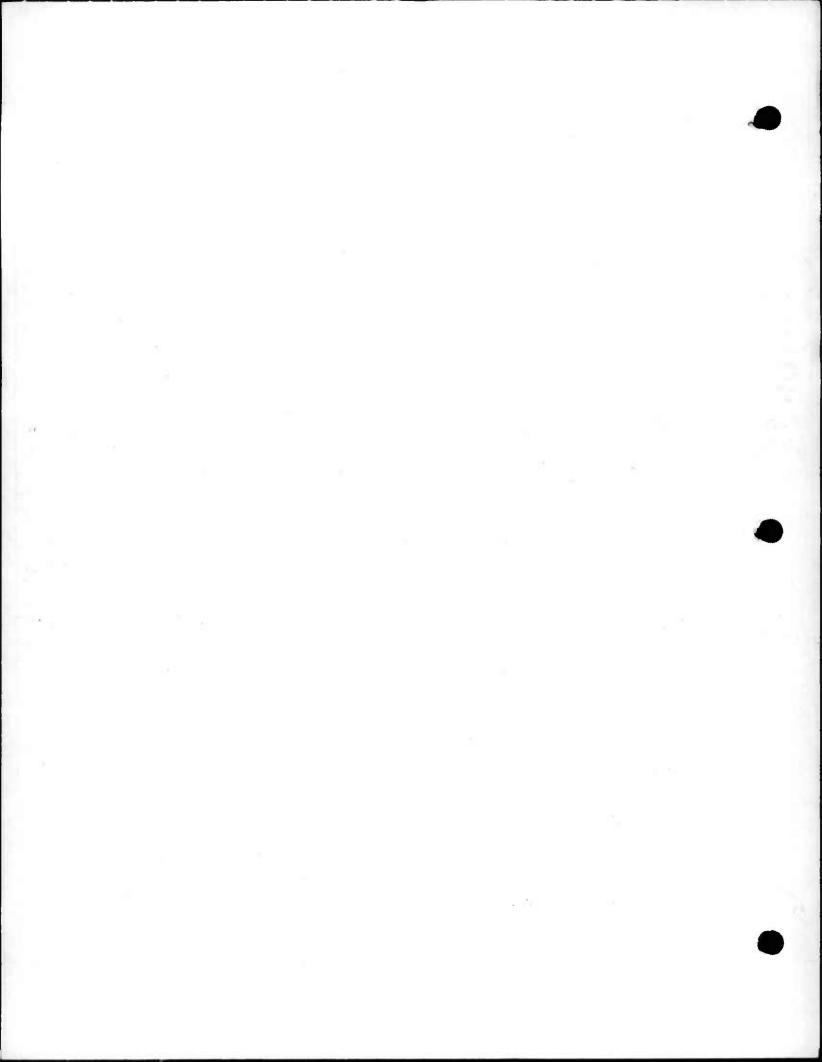
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CADSE OF DEATH (ITEM 27) (Type, Print) 3305

C. Ozan Ne-Blankfard Siver

31. DATE FILEO (Month, Day, Year)

32. REGISTRAR'S SIGNATURE

JUL 20 1995 Julia Daurelian Randall



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within after death. Page 6 may be retained by the hospital or attending physician and completely filed in by the funcial director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hyghere prior to burial, cremation, or removed.

IMPORTANT: It item 28 is marked, or item 23 shows any Injury, or other traumatic event. The medical examiner must he marked, and item 28 is marked.

		FOR 1 - STATE REGISTRAR	STATE OF MARYL			OF HEALTH AND			🗸 🗸 💈		
		1. DECEDENT'S NAME (First, Middle, Last) HOWARD GEORGE I	FNNON .TP		ICALE	OF DEATH	PEG. NO 2. DATE OF DEATH MONTH JULY 22,	3. TIME OF DEATN			
	- 6			In yrs. last birthday)	IF UNDER	YEAR IF UNDER 24 HRS.	JULY 22,		12:03A M		
מים זוני מסומי הייניי לייניי ומאפט ו' צ'י מי מוחמות	ĺ	219-76-4713 1 9e. FACILITY NAME (If not institution, give stree	₩ 2 □ F	51 YRS.	MONTHS	DAYS HOURS MIN.	March 1,	1944 к	country) entucky		
	TOR	73 Ridge Road		rown on Location of Diestminster	EATH	roll					
	DIRECTOR	100. STATE 10b. COUNTY Maryland Cari	ro11			nster			10d. INSIDE CITY LIMITS? 1 YES 27 NO		
	RAL	10e. STREET AND NUMBER 73 Ridge Road			COOM	10f. ZIP CODE			OF WHAT COUNTRY?		
	FUNERAL		2. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED		21157 AS DECENDENT OF HISPAI yes, specify Cuben, Mexica		d States RACE — American Indian, Black, White, etc.			
	D BY	3 Widowed 4 Divorced		YES, GIVE WAR OR DATES 1 YES 2 NO 3							
	ETE	15. OECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	ION npleted) College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ASSEMBLY			Sheltered Workshop C.C.A.R.C.				
опсе.	COMPL	17. FATHER'S NAME (First, Middle, Last)		Ansoc	поду	16 MOTNER'S NA	ME (First, Middle, Meiden				
5	BE C	Howard George Lenr	non, Sr.			Mildre	d Blackbur	n			
ner must be notified	٩	Evelyn C. Lennon				(Street and Number or Rural Road, Westm			<u> </u>		
		20a. METHOD OF DISPOSITION 1 № Burlel 2 □ Cremation 3 □ Remova 4 □ Donetion 5 □ Other (Specify)	from State cemi	PLACE AND DATE	ther plece)	rion (Neme of Cemetery			or Town, State		
	1	21. SIGNATURE OF FUNERAL SERVICE LICENS		adow br		IAME AND ADDRESS OF FA		CHITHSTE	er, Maryland		
or removal. medical examiner		Sular Flakht Mulls Myers Funeral Home 91 Willis Street, Westminster, MD 21157									
ul, cremation, event, the		23. PART i. Enter the diseases, pr com shock, pr heert fellure. Lis	iplications that caused t only one cause on as	the death. Do	not enter t	tha mode of dying, suc	h es cardiec or respi	ratory srrest	Interval Between		
		iMMEDIATE CAUSE (Final disease or condition resulting in death)	RESPIRA	FF	TIMPE			Onset and Death			
	z		RESPIRATORY FAILURE 2days DUE TO (OR AS A CONSEQUENCE OF): ALZHEIMER DISEASE 5 year								
giene prior to buris other traumatic	ATIO	If any, leeding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE O	F):						
Hygiene p or other	CERTIFICATION	CAUSE (Disease or injury thet initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):						
vertal	2	DADT II Other classificant and distance									
th and	EDICAL	PART II. Other significent conditions of	YNPROM	E /	EP L	LEPSY	Pert i. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
Dept. of Heaf	AN: M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
State Dept.	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? BY A CASE REFERRED TO MEDICAL CONTROL									
the St	IXSI	1 TYES 2 NO 1	☐ Inpatient 2 ☐ ER/Outpa			ng Home 5 Testdence	6 Other (Specify)				
marked,	BY PHY	27. MANNER OF DEATN 1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year) INJURY W			26c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW II	BE HOW INJURY OCCURED			
after d	TED	3 Suicide 8 Could not be determined	26e. PLACE OF INJURY building, etc. (Speci	— At home, ferm,	street, facto	ry, office	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
2 =	OMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL ONE) 2 MEDICAL EXAMINER: C							use(a) and menner as stated.		
be filed within IMPORTANT:	O BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	MD			29c. LICENSE NUM			GNED (Month, Day, Year)		
	$\tilde{\Gamma}$	30, NAME AND ADDRESS OF PERSON WHO C									

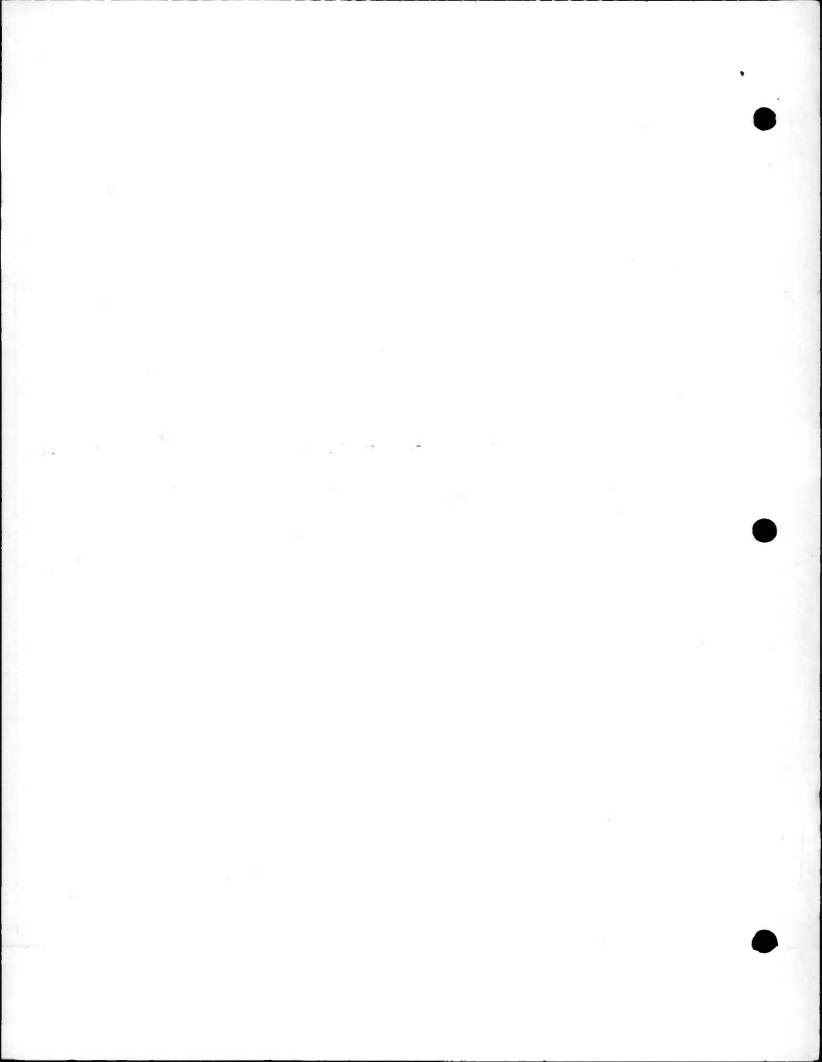
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

ANDKEW WARREN MD JOHNS HOPKING HOSKITAL, BALTIMORE

32. REGISTRAR'S SIGNATURE

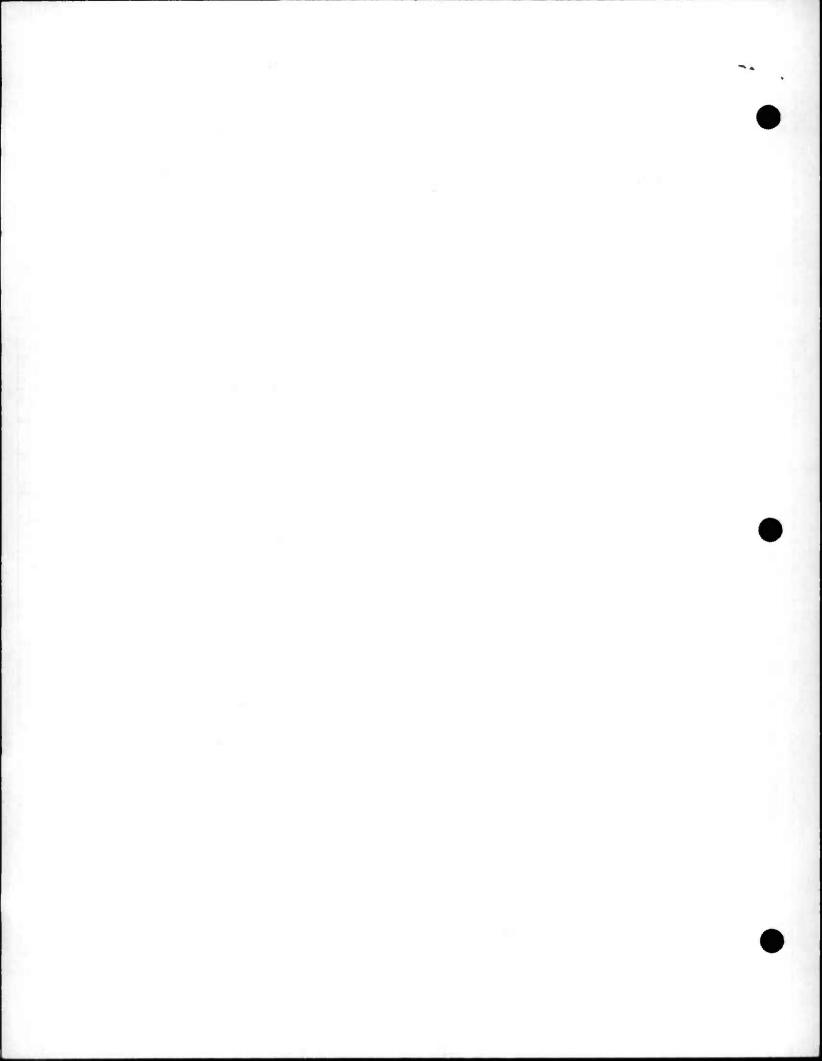
31. DATE FILED (Month, Day, Year)

MD



FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Lest) A SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthdey) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign														
	Margaret Mar	y lago				7 19		/-	722 PM						
	4. SOCIAL SECURITY NUMBER 5. S 2//- 32-7 972 1	SEX 8. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		Country)	ACE (State or Foreign						
			FJ YRS.	DATS	HOURS WIN.	12-16-	09		aryland						
~	9e. FACILITY NAME (If not institution, give street a		1.6		OR LOCATION OF DEA		9c. COUNT								
DIRECTOR	RESIDENCE OF DECEDENT	, MO	21157	WINT	noter m	10 2/157	Co.	11011							
2	10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	TION			10	d. INSIDE CITY						
뜸	MD Carro	11	We	stmins	ster			χ.	LIMITS? YES 2 NO						
4	10e. STREET AND NUMBER				, ZIP CODE		10g, CITIZE		T COUNTRY?						
ER/	50 Timber Ridge	Drive		21157					States						
FUNERAL	11. MARITAL STATUS 12.	WAS DECEOENT EVER IN	U.S. ARMED	S. ARMED 13. WAS DECEMBENT OF HISPANI			NIC ORIGIN? (Specify Yes or No. 14. RAC								
BY F		FORCES? 1 YES		NO II yes, specify Cuben, Mexican											
					-X				white						
COMPLETED	15. DECEOENT'S EDUCATIO (Specify only highest grade comp	N vieted)	(Give kind of wo	SUAL OCCUPATION rk done during most retired.)	ON st of working	16b. KIND OF BU	SINESS/INDU	STRY							
7	Elementery/Secondary (0-12) Co	flege (1-4 or 5+)		retired.)											
N N	17. FATHER'S NAME (First, Middle, Lest)		clerk			Hechi	-								
		essner				E (First, Middle, Maiden	,								
BE	19e. INFORMANT'S NAME (Type/Print)	essuer	10h MAII INC A	DDBESS (Daniel	Bertha	ute Number, City or Tow	Sma1		a						
2	Dennis Lego								11226						
	20a. METHOD OF DISPOSITION	20b	PLACEANDDATEOE	DUTTUAW	medica a da	Baltimo	CATION CH	D Z	1236						
	1 Suriel 2 Cremation 3 Removal f 4 Donation 5 Other (Specify)	rom Stale cem	etery, crematory or othe	er place)	7/22/95	OATE 20c. LO									
	21. SIGNATURE OF FUNERAL SERVICE LICENSE	E .	rraine	22. NAME AN	emetery	LITY									
İ	b			Prit	ts Fune	ral Home	& C	hape	1						
	23. PART I. Enter the diseases, or comp	to - Swei	ter	412	Washing	ton Rd.	Wes	tmin	ster, MD						
	enock, or neert failure. List o	only one ceuse on ee	ech line.	t enter the mod	de of dying, auch	es cardiec or reepi	ratory erres	it,	Approximats interval Between						
	IMMEDIATE CAUSE (Finel disease or condition				/				Onset and Death						
1	disease or condition resulting in death) s. MYOCANDIAC INFORCTION DYINY WINNER DUE TO (OR AS A CONSEQUENCE OF):														
_	DUE TO (OH AS A CONSEQUENCE OF):														
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate	OUE TO (OR AS A	CONSEQUENCE OF):						Vahrung						
8		HIPER TEN	NON						11						
E	that initiated events		CONSEQUENCE OF):												
H H	resulting in desth) LAST														
	PART II. Other eignificent conditions cor	ntributing to death bu	it not resulting in	PART II. Other eignificent conditions contributing to death but not requiring in the underlying to death but not											
8	PERFORMEO? AM														
S	Nuas Paus die		the underlying	ceuse given in Pe	PERFOR	MEO?	AWA	RE AUTOPSY FINDINGS VILABLE PRIOR TO							
EDI	- Hypolhyodin				ceuse given in Pe	24a. WAS AN PERFOR	MEO?	CDI OF	MPLETION OF CAUSE DEATH?						
I: MEDICAL		TE TO CAUSE OF	F DEATH VES			PERFOR	MEO?	CDI OF	MILABLE PRIOR TO MPLETION OF CAUSE						
	DID TOBACCO USE CONTRIBU		F DEATH YES	□ NO □		PERFOR	MEO?	CDI OF	MPLETION OF CAUSE DEATH?						
	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL:	26. PLACE OF DEATH	OTHER:	UNCERTAIN	PERFOR	MEO?	CDI OF	MPLETION OF CAUSE DEATH?						
	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL: Inpatient 2 FR/Outpate 28e. DATE OF INJURY	26. PLACE OF DEATH Itlent 3 DOA 4	(Check only one) OTHER: Nursing Home DF 28c, INJU	UNCERTAIN 5 Reeldence 8 JRY AT 2	PERFOR	MEO?	CDI OF	MPLETION OF CAUSE DEATH?						
PHYSICIAN:	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 70 1 1 7. MANNER OF OEATH 1 Netural 5 Pending	SPITAL: Inpatient 2 PER/Output 28e. DATE OF INJURY (Month, Dey, Year)	26. PLACE OF DEATH	(Check only one) OTHER: Nursing Home OF 28c. INJU	UNCERTAIN 5 Reeldence 8 JRY AT 2	PERFOR 1 YES 2 Other (Specify)	MEO?	CDI OF	MPLETION OF CAUSE DEATH?						
BY PHYSICIAN:	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 700 1 Pending Investigation 3 Suicide 6 Could not be	SPITAL: Inpetient 2 PER/Output 28e. DATE OF INJURY (Month, Day, Vear) N) 26e. PLACE OF INJURY	28. PLACE OF DEATH atlant 3 DOA 4 28b. TIME (INJUF	(Check only one) OTHER: Nursing Home Nursing Home WOF 1 Y	UNCERTAIN 5 Reeldence 8 JRY AT 2 ES 2 NO	PERFOR 1 YES 2 Other (Specify) Other (Specify) 661. LOCATION (Street a	MEO?	AWA CDI OF	NLABLE PRIOR TO MPLETION OF CAUSE DEATH?						
BY PHYSICIAN:	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 1 7. MANNER OF OEATH 1 Netural 5 Pending Investigation 1 Netural 1 Pending 1 Netural 1 Netural 1 Pending 1 Netural 1 Netural 1 Pending 1 Netural 1 Netu	SPITAL: Inpetient 2 PER/Outpet 28e. DATE OF INJURY (Month, Day, Year)	28. PLACE OF DEATH atlant 3 DOA 4 28b. TIME (INJUF	(Check only one) OTHER: Nursing Home Nursing Home WOF 1 Y	UNCERTAIN 5 Reeldence 8 JRY AT 2 ES 2 NO	PERFOR 1 YES 2 Other (Specify) Red. DESCRIBE HOW II	MEO?	AWA CDI OF	NLABLE PRIOR TO MPLETION OF CAUSE DEATH?						
BY PHYSICIAN:	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	SPITAL: Inpatient 2 PER/Output 28e. DATE OF INJURY (Month, Day, War) N A 26e. PLACE OF INJURY building, etc. (Speci	28. PLACE OF DEATH without 3 DOA 4 28b. TIME (INJUE) At home, lerm, street, st	(Check only one) OTHER: Nursing Home Nursing Home Nursing Home Nursing Home Nursing Home Nursing Home Nursing Home Nursing Home Nursing Home Nursing Home Nursing Home Nursing Home Nursing Home Nursing Home Nursing Home	UNCERTAIN 5 Reeldence 8 JITY AT RKY ES 2 NO	Other (Specify) Other (Specify) Other (Specify) Other (Specify) Other (Specify) Other (Specify)	JURY OCCUR	AMCO'OF	NLABLE PRIOR TO MPLETION OF CAUSE DEATH?						
BY PHYSICIAN:	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	SPITAL: Inpatient 2 PER/Outpi 28e. DATE OF INJURY (Month, Day, War) N) 26e. PLACE OF INJURY building, etc. (Speci	28. PLACE OF DEATH whilent 3 DOA 4 28b. TIME (INJUR At home, lerm, stru	(Check only one) OTHER: Nursing Home OF WO 1 U y eet, factory, office	UNCERTAIN 5	Other (Specify) 28d. DESCRIBE HOW II 261. LOCATION (Street as City or Town, State)	JURY OCCUR	AMACON OF	NLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO Number,						
COMPLETED BY PHYSICIAN:	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	SPITAL: Inpatient 2 PER/Outpi 28e. DATE OF INJURY (Month, Day, War) N) 26e. PLACE OF INJURY building, etc. (Speci	28. PLACE OF DEATH whilent 3 DOA 4 28b. TIME (INJUR At home, lerm, stru	(Check only one) OTHER: Nursing Home OF WO 1 U y eet, factory, office	UNCERTAIN 5	Other (Specify) Other (Specify) 161. LOCATION (Street a City or Town, State) 164. couse(e) end manne, date end place, en	AJURY OCCUR	AMACOLOGO PARA PARA PARA PARA PARA PARA PARA PAR	NLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO Number,						
BE COMPLETED BY PHYSICIAN:	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	SPITAL: Inpatient 2 PER/Outpi 28e. DATE OF INJURY (Month, Day, War) N) 26e. PLACE OF INJURY building, etc. (Speci	28. PLACE OF DEATH whilent 3 DOA 4 28b. TIME (INJUR At home, lerm, stru	(Check only one) OTHER: Nursing Home OF WO 1 U y eet, factory, office	UNCERTAIN 5	PERFOR 1 YES 2 Other (Specily) 186. LOCATION (Street a City or Town, State) the cause(e) end manne, date and place, ender	AJURY OCCUR Ind Number or There e stated. If due to the company of the company	AMA CODI OF 1 []	MLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO Number, Number, d manner as stated.						
E COMPLETED BY PHYSICIAN:	DID TOBACCO USE CONTRIBU 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 1 27. MANNER OF OEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On 29b. SIGNATURE AND TITLE OF CERTIFIER WHALL S. STATE 30. NAME AND ADDRESS OF PERSON WHO COM-	SPITAL: Inpatient 2 PER/Outpe 28e. DATE OF INJURY (Month, Dey, War) A A 26e. PLACE OF INJURY building, etc. (Speci	28b. PLACE OF DEATH without 3 DOA 4 28b. TIME (INJUR At home, term, streetly) and or investigation, and or investigation,	Check only one) OTHER: Nursing Home Nursing Home OF WOF M 1 V pet, factory, office at the lime, date of in my opinion, de	UNCERTAIN 5 Reeldence 8 JRY AT 2 RK? ES 2 NO 2 and place, end due to esth occured at the time 29c. LICENSE NUMBER 0/7526	PERFOR 1 YES 2 Other (Specify) 18d. DESCRIBE HOW II 166. LOCATION (Street a City or Yown, State) The ceuse(e) end manne, date and place, ender	AJURY OCCUR Ind Number or There e stated. If due to the company of the company	AMACOLOGO PARA PARA PARA PARA PARA PARA PARA PAR	MLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO Number, Number, d manner as stated.						
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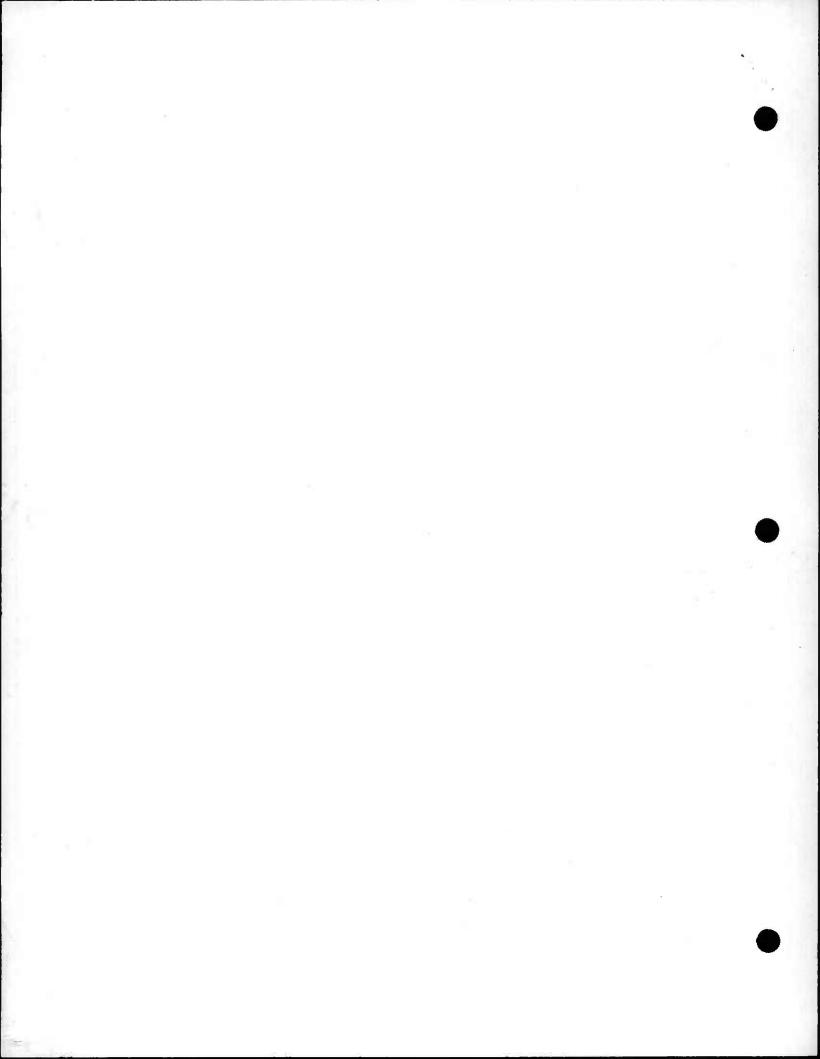
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. P	be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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Dr. Sergio Mateo
31. DATE FILED (Month, Day, Year)
JUL 2 4 1995

32. REGISTRAR'S SIGNATURE

								the state of	U	23381		
_	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR RTIF	TMENT OF	HEALTH AND	MENTAL HYGIE					
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH			3. TIME OF DEATH		
	Jesse Lin	n	LI	NDSA	Y		July 21,	1995	YEAR	9:20 p м		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		a aigm	IPLACE (State or Foreign		
	217-07-1603	17 M 2 F	81	YRS.	MONTHS DAYS		(Month, Day, Year)	014	Count	y)		
	9e. FACILITY NAME (If not institution, give :	1	01				3/18/1			ryland		
<u>~</u>			L = 1			OR LOCATION OF DE			UNTY OF D			
2	Franklin Squar	e Hospi	tal		White	Marsh	area	rea Baltimore				
EG	10a. STATE 10b. COUNT	Y		10c CIT	Y, TOWN OR LOC	ATION		10d. INSIDE CITY				
DIRECTOR	MD Bal	timore						10				
	10e. STREET AND NUMBER		B9	ltimo					1 TES 2 1 NO			
A A						Of. ZIP CODE		10g. Cl	TIZEN OF V	VHAT COUNTRY?		
FUNERAL	8731 Avondale					21234		Un:	ited	States		
5	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. ARI	MED O	13. WAS D	ECENDENT OF HISPAN	NIC ORIGIN? (Specify	fee or No-	14. RACE	— American Indien, c, White, atc.		
Æ	3 Widowed 4 Divorced		YES 2 N			S 2 X NO Specify			Speci			
			II							white		
12	15. DECEDENT'S EDU (Specify only highest grade	completed)	(Gh	ve kind of v	USUAL OCCUPATION OF COMMERCE O	FION nost of working	166. KIND OF E	USINESS/IN	IDUSTRY			
빌	Elementary/Secondary (0-12)	College (1-4 or 5	1)	Do NOT us								
COMPLETED	8		Co-	-own	ed & c	perator			lon			
8	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NA	ME (First, Middle, Maid	en Surname)				
H		Lindsay				Addie		Fran		n		
0	19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)											
-	Elizabeth Lindsay 8731 Avondale Rd., Baltimore, MD 21234											
	20e. METHOD OF DISPOSITION 1) Burlel 2 Cremation 3 Rem	ound from State	20b. PLACEA	NDDATE	F DISPOSITION /	Name of 7 / 24 /	O S DATE 20c.	OCATION -		wn, State		
	4 Donation 8 Other (Specify)	Oval from State	cametery, crem	natory or o	nerpiace)	cah Como	+ b	Tere I	7.2 A	160		
1 1	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE			22. NAME	rch Cemetery New Windsor, MD E AND ADDRESS OF FACILITY itts Funeral Home & Chapel						
		0.	, .		Pri	tts Fun	eral Hor	ne &	Cha	pel		
	Katherine.	Pretto-	- Sweets	1	412	Washin	aton Rd.	We We	stm	inster, MD		
	23. PART I. Enter the diseases, preshock, or heart fellure.	complications that List only one cay	t caused the dec	th. Do n	ot enter the n	ode of dying, such	h es cerdiec or res	piratory si	rrest,	Approximete		
	IMMEDIATE CAUSE (Fine)											
	disease or condition									Interval Between Onset end Death		
1 1	resulting in death)	Congest	tive hear	rt fa	ailure							
	resulting in death)		tive hear							Onset end Death 3 days		
Z		DUE TO	(OR AS A CONSEO	UENCE OF	7):	obstructi	ve pulmon	ary d	iseas	Onset end Death 3 days		
TION	Sequentially list conditions, if any, leading to immediate	Severe	(OR AS A CONSEO	ge cl	nronic (obstructi	ve pulmon	ary d	iseas	Onset end Death 3 days		
CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	Severe	on as a consecuent	ge cl	nronic (obstructi	ve pulmon	ary d	iseas	Onset end Death 3 days		
TFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	Severe DUE TO	on as a consecuent	UENCE OF	nronic (obstructi	ve pulmon	ary d	iseas	Onset end Death 3 days		
ERTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	Severe DUE TO	OR AS A CONSEC end stag (OR AS A CONSEC	UENCE OF	nronic (obstructi	ve pulmon	ary d	iseas	Onset end Death 3 days		
CERTIFICATION	Sequentially liet conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO b. Severe DUE TO c. DUE TO	(OR AS A CONSEO	NENCE OF	nronic (ary d	iseas	Onset end Death 3 days		
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9000 Franklin Square Dr. Baltimore, Maryland 21237



iours after death. Page 6 may be retained by the hospital or attending physician. d in by the funeral director, page 5 should be detached for use as the burial-trar BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

use as the bunal-transit permit.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	ITTENDING PHYSICIAN: TI
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_	HOSPITAL

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATN YEAR July Vance C. Largent, Sr 9 1995 12:44 P.M 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign Country) DAYS HOURS 1 M 2 - F YRS 233-40-9866 66 Nov. 15, 1928 Virginia 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATN DIRECTOR Memorial Hospital Cumberland **Allegany** 10e. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? W Va 1 X YES 2 NO Morgan Paw Paw 10e. STREET AND NUMBER FUNERAL 101. ZIP COOE 10g. CITIZEN OF WNAT COUNTRY? O. Box 304 25434 S 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES 13. WAS OECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—
If yee, specify Cuben, Mexican, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 X Merried BY 1 TYES 2 NO Specify: Specify: 3 Widowed 4 Divorced **Black** COMPLETED 15. OECEDENT'S EOUCATION 16e. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Custodian Paw Paw Schools once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Melden Surneme) Ħ BE Grafton Largent <u>Hazel</u> Spencer notitled 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) ၀ Wilma M. Largent Box. 304 Paw Paw. 25434 W. Va. be 20e. METNOO OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must 1 Buriel 2 Cremetion 5 Other (Specify) Removal from State Camp Hill Cemetery 7-13-95 Paw Paw, W. Va the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LIGES 22. NAME AND ADDRESS OF FACILITY Miller Funeral Home Winchester & Lee St. 25434 Paw Paw. W Va. 23. PART I Enter the diseases, or complications that caused the des ehock/or heert fellure. List only one ceuee on each line. complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Interval Between Onset and Death **IMMEDIATE CAUSE (Finel** disease or condition Arteriosclerotic cardiovascular disease Unknown years resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): thet initiated evanta resulting in deeth) LAST 0 injury, PART II. Other algoliticent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINGINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? PERFORMEO? shows any 1 TYES 2 X NO 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF OEATN (Check only one) item HOSPITAL:
1 | Inpatient 2\(\) ER/Outpatient 3 | DOA OTHER: 1 X YES 2 NO 4 ☐ Nursing Home 5 ☐ Reeldence 8 ☐ Other (Specify) 6 27. MANNER OF OEATN 28e. OATE OF INJURY (Month, Day, Yeer) 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCUREO 28b. TIME OF marked, 1X Natural Pending toveatigation L DIRECTOR: After the hours after death with them 28 is mark 1 YES 2 NO ВУ 2 Accident 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Nomicide 29e. CERTIFIER 1 _ CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. (Check only one) 2 [X MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(e) end menner as attated. TO THE HOSPITA
TO THE FUNERA
De filed within 7. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Deputy Med. Ex.

PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) D 09157 July 9. 1995 9

Snow.

31. OATE FILED (Month, Day, Year)

24

W.

32. REGISTRAR'S SIGNATURE

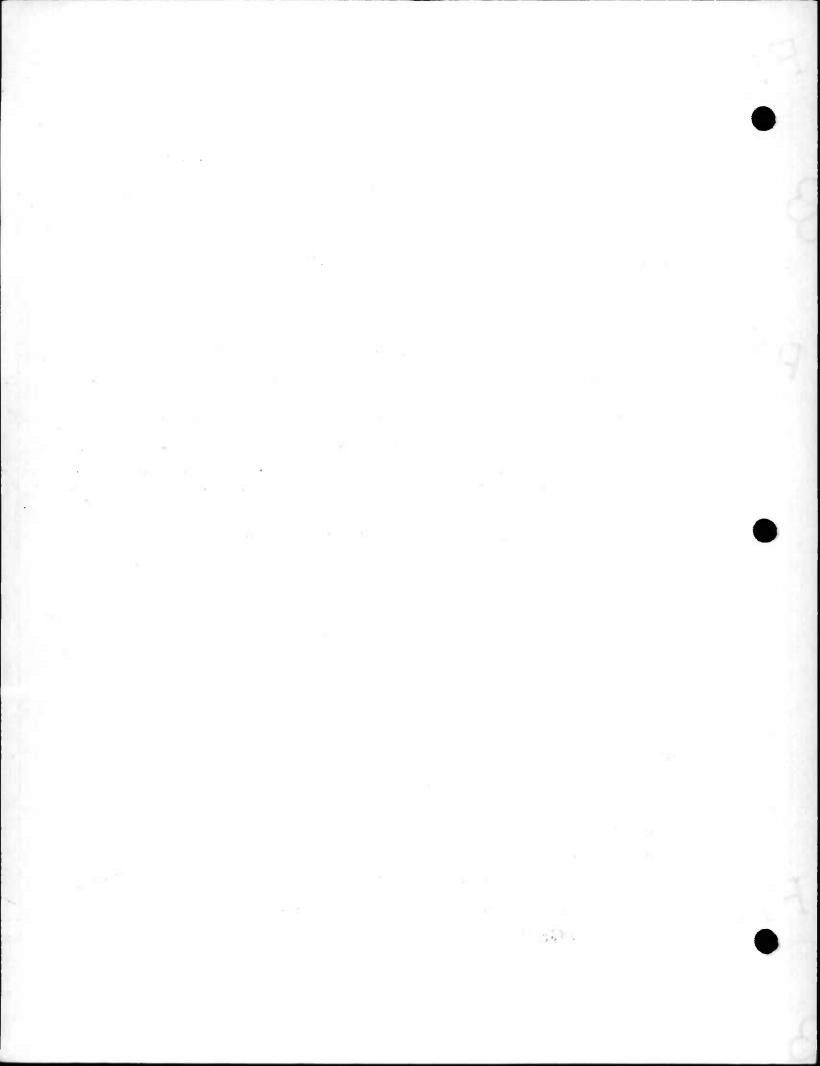
3rd Street

John Danden-Randall

Cumberland, Md.

21502

FUNERAL I



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Thours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF I	HEALTH AND	MENTAL HYGIEN		20000				
- 1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
	Lucille	Maud Leitcl	n			July 13.	1995 YEAR	11:20 P M				
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	6, Bir	TTHPLACE (State or Foreign				
	220 02 7320	□ M 2 XXF 8	YRS.	MONTHS DAYS	HOURS MIN.	10-24-12	Ğ	uyana				
	9a. FACILITY NAME (If not institution, give street	and number)		96. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUNTY O					
DIRECTOR	1617 Owens Road			0x	on Hill		Prince	George's				
<u> </u>	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10c CI	Y, TOWN OR LOCA	TION							
H	Maryland Prince	e George's	1000				10d. INSIDE CITY LIMITS?					
	10e. STREET AND NUMBER	e deorge s		0xon 1	1 I I I I		10c CITIZEN O	1 TYES 2 TO NO				
FUNERAL	1617 Owens Road				20745	5	log. Grizzii G	USA				
S		. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DE		NIC ORIGIN? (Specify Ye	8 or No 14, R/	NCE — American Indian,				
ВУ Е	1 Never Married 2 Married	FORCES? 1 YES			ecify Cuban, Mexico 2 [X] NO Specia	an, Puerto Rican, atc.)	BI	ack, White, etc.				
	3 ¥ ¥ Widowed 4 □ Divorced				**			B1ack				
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade com	ON hpleted)	16a. DECEDENT'S	USUAL OCCUPATI work done during ma ise retired.)	ON ost of working	16b. KIND OF BU	SINESS/INDUSTRY					
7	Elementary/Secondary (0-12) c	college (1-4 or 5+)										
M	17. FATHER'S NAME (First, Middle, Last)		Teac	her			entary S	chool				
	Gerald Mar	ahall			16. MOTHER'S NA	AME (First, Middle, Malden						
BE	19a. INFORMANT'S NAME (Type/Print)	Silall	19b. MAILING	ADDRESS (Street	and Number or Burni	Isabel Fra Route Number, City or Tow	IZIEr					
2	Carmen A. Adams			Owens Ro		Hill, Mar		0745				
	20a. METHOD OF DISPOSITION	20b.		OF DISPOSITION /N		OATE 20c. LO						
	cometery comments of the composition of the composi											
	21. SIGNATURE OF FUNDRAL SERVICE LICENS	ye.		22. NAME A	ND ADDRESS OF FA	as Funeral	TT TT	aryrand				
	> ///mf / ////	12						41 207/5				
\neg	23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
	Shock, or neart failure. List	only one ceuse on e	ch line.	not enter the mit	de Di dynig, suc	in an cardiec or reep	iratory arreat,	Interval Between Onset and Death				
	MMEDIATE CAUSE (Final disease or condition resulting in death) o. CORONARY ARTORY DISEASE											
	resulting in death) e	DUE TO (OR AS A			1 22	CN-C		3 YRS				
z	20. SIN 1820 F. A. C. C. C. C. C. C. C. C. C. C. C. C. C.											
CERTIFICATION	Sequentially liet conditiona, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE O	F):								
2	cause. Enter UNDERLYING CAUSE (Disease or Injury											
E	that initieted events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE O	F):								
H	d											
	PART II. Other algolificent conditions co	ontributing to death be	t not resulting	In the underlyin	g cause given in			4b. WERE AUTOPSY FINDINGS				
2	CELEBROVA	SCHLAR	DIC	DASE.		PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE				
AEC							4xhmo	DF OEATH?				
ä	DID TOBACCO USE CONTRIB	UTE TO CAUSE O	DEATH Y	S NOTE	UNCERTAIL	ND						
PHYSICIAN: MEDICAL	25. WAS CASE REFERRED TO MEDICAL			TH (Check only one)								
Sic		OSPITAL: Inputient 2 ER/Output	tlent 3 🗆 DOA	OTHER: 4 Nursing Hore	e 5, Thesidence	6 Other (Specify)						
E	27. MANNER OF OEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIN		URY AT	26d. DESCRIBE HOW I	NJURY OCCURED					
BY	Natural 5 Pending Investigation			M 1 🗆								
	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, atc. (Speci	At home, farm,	street, factory, offic	•	261. LOCATION (Street (City or Town, State)	and Number or Run	I Route Number,				
E I	4 Homicide determined											
COMPLETED		: To the best of my knowle										
Ö	one) 2 MEDICAL EXAMINER: O	n the basis of axamination	and/or investigation	on, in my opinion, d	eath occured at the	time, date and place, an	d due to the cause	e(s) and manner as stated.				
BE 0	29b. SIGNATURE AND TITLE OF CERTIFIER	20/5			29c. LICENSE NUI	MBER	29d. DATE SYGNI	ED (Month, Day, Year)				
TO B	Sexe	7110	2		2	8281	▶ 7 1.	4/95				
-	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Туре	Print) Nelso	n V. Ben	jers, M.D.	-					
	0726 WOOD!	JACO K	D B	109 (lintor	in ind	. 20	135				
	31. DATE FILEO (Month, Day, Year) JUL 17 1985											

Martin 19 A

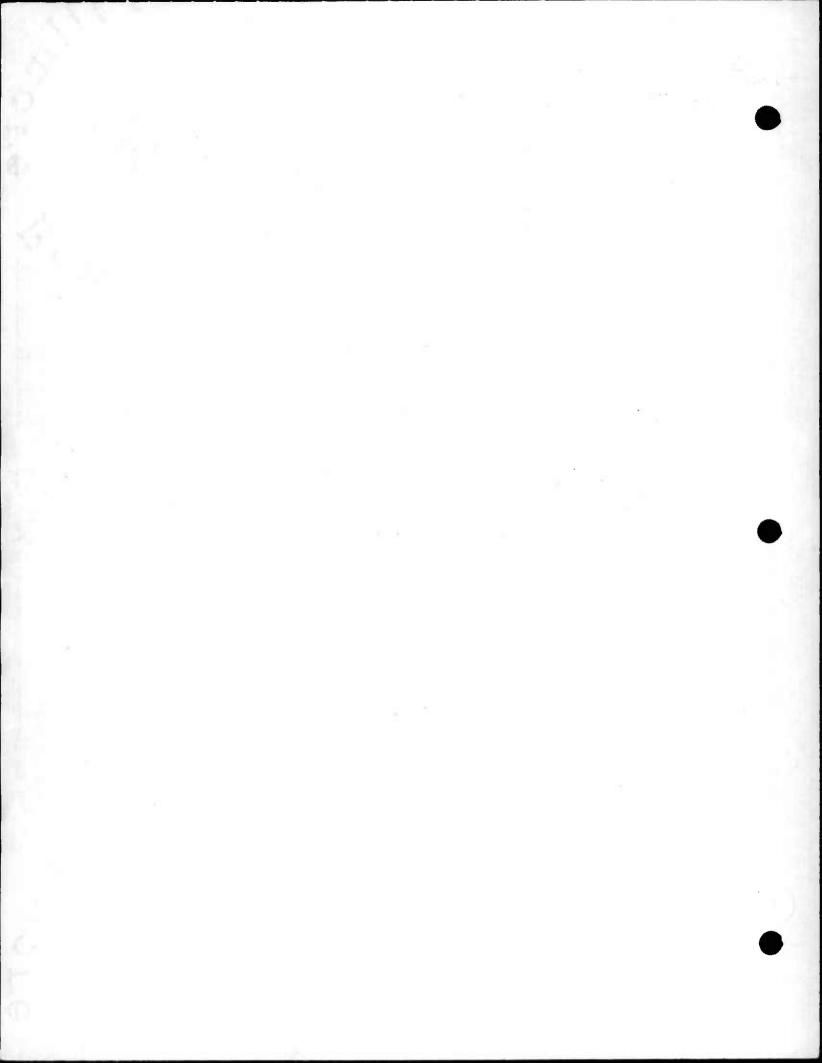
BALTIMORE, MARYLAND 21215-0020	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
TO THE HOSPITAL OR ATTENDING PHY	TO THE FUNERAL DIRECTOR: An be filed within 72 hours after de	IMPORTANT: If Item 28 is marked	

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH															
	Pai-Lin		Lee							July	16		995	1:00 p M		
	4. SOCIAL SECURITY NUME	BER	5. SEX	8. AGE (In yrs. less	birthday)	IF UNDER		#F UNDER	24 HRS.	7. DATE OF B	WETH	, .	8. BIRTH	IPLACE (State or Foreign		
	220-27-448	-	1 🔀 M 2 🗆 F	88	YRS.	MONTHS	DAYS	HOURS	MIN,	(Month, Day Dec.	13,	1906	l Count	V.		
_	9e. FACILITY NAME (If not in					9b. CITY	, TOWN	OR LOCATI	ON OF DE				NTY OF D			
5	8010 Craddo		d			Gr	eenb	e1t				Prince George's				
EC	10a. STATE	10b. COUNTY	,		10c. CIT	Dc. CITY, TOWN OR LOCATION 10d, INS						10d. INSIDE CITY				
듬	Maryland	Princ	e George	's	Gre	enbe	1t							LIMITS?		
AL	104. STREET AND NUMBER					10f. ZIP CODE					10g. CITIZEN OF WHAT COUNTRY?					
FUNERAL DIRECTOR	8010 Cradd	ock Ro	ad			20770					Chi	China				
5	11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AR	MED 13. WAS DECENDENT OF HISPANIC (NO II yes, specify Cuben, Mexican, P				C ORIGIN? (Specify Yes or No — 14. RACE — Puerto Block, V				— American Indian, c, White, atc.			
ВҰ	3 Widowed 4 Divo		IF YES, GIVE Y	MAR OR DATES				2 ∑ NO			,,		Speci			
ED	15. DECEDENT'S EDUCATION 188, DECEDENT'S USUAL OCCUPATION 165 KIND OF BUSINESS UNDUCTOR															
COMPLETED	Elementery/Secondary (0		College (1-4 or 5	+) (Gi	ve kind of Do NOT u	work done se retired.)	during mo	st of working	g							
MP			5+	Gen	era1	Man	ager			Aut	omob	ile	Indu	stry		
응	17. FATHER'S NAME (First, M P.S. Lee	liddle, Last)								ME (First, Middle		Surname)				
BE	190. INFORMANT'S NAME (7	Sup o (Christ)								n) Tan						
5	Kwei-Tsen									Route Number, C				00770		
	20e. METHOD OF DISPOSITI	ION		20h PLACEA	NODATE	OF DISPOS	ITION /A/o	mo of		reenbe	200 100	ATION	014 T-	21-1		
	20b. METHOD OF DISPOSITION 1															
		1. SIGNATURE OF FUNERAL SERVICE LICENSEE								22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A.						
	> Clian		F1	ranc	is Ga	asch	's Son	s Fu	neral	l Hor	ne, P.A.					
	23. PART i. Enter the di	omplications tha	ng. auch	e Ave.	Hya:	ttsv:	ille.	MD 20781								
	ahock, or he iMMEDIATE CAUSE (Fin	eart failure.	List only ona cat	use on each line.							/		001,	intarval Between Onset and Daath		
	immediate cause (Final disease or condition as Due to (OR AS A CONSEQUENCE OF): Onset and Death Due to (OR AS A CONSEQUENCE OF):															
	DUE TO (OR AS A CONSEQUENCE OF):															
NO	Sequentially list conditions, Due to (or as a consequence or)															
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING															
FIC	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):											-				
F	resulting in death) LAST												ļ [
Ö	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS															
MEDICAL				wouth but not re	outing	uiting in the underlying cause given in Pa			Part i. 24a. WAS AN AUTOPSY PERFORMED?			246.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE			
Ē										_ 10	YES 2	NO		OF DEATH?		
	DID TOBACCO US	SE CONTR	IBUTE TO CA	USE OF DEAT	H YE	S \square 2	VO IZ	LINC	FDTAIN					1 YES 2 NO		
¥	25. WAS CASE REFERRED TO EXAMINER?					TH (Check		0110	EKIMI							
YSIC	1 YES 2 TO NO		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER	R: sing Home	5 NA.	sidence	8 Other (Spe	icify)					
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF (Month, D		28b. TIM INJ	E OF URY	28c. INJU	URY AT		28d. DESCRIB	E HOW IN	JURY OCC	URED			
ΒY	2 Accident	Pending Investigation				M		'E\$ 2 [NO NO							
		Could not be determined	28e. PLACE O building,	F INJURY — At hon atc. (Specify)	ne, ferm, s	street, fect	ory, office			281. LOCATION City or Tox	(Street ar	nd Number	or Rurai R	oute Number,		
COMPLETED	290. CERTIFIER															
MP	(Check only			my knowledge, dea												
8			CH the best of a	xamination end/or in	rveatigatio	n, In my o	pinion, de	eath occur	ed at the t	time, date and p	piece, end	due to th	e cause(e)	end menner ea stated.		
H(006. SIGNATURE AND TITLE	OF CENTIFIER	a ok	200				29c LICE	SE NUM	39		29d. DATE	SIGNED	(Month, Day, Year)		
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CALIS	SE OF DEATH (ITEM	27) (Tune	Printi		21					///	7/75		
	Tsunie Chan			824 Cunn			rive	Ro	707.75790	Hojoh	to	V.o.	10=1	207/0		
ı	31. DATE FILED (Month, Day,)	Mear)		R'S SIGNATURE	4	Lam D	V C	, пе	L W y I	neign	LS,	пагу	Talld	20/40		
31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE JUL 19 1995 July D'Audien Randall																



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687604

PHYSICIAN: MEDICAL CERTIFICATION

BY

COMPLETED

BE

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH Israel Malamud July 17, 1995 1:30 PM 8. BIRTHPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 578-48-6908 DAYS 94 HOURS 1 XM 2 - F YRS. Sep. 15, 1900 Russia 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH DIRECTOR Hebrew Home of Greater Washington Rockville Montgomery 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Md. Montgomery Rockville 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 6121 Montrose Rd. 20852 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, etc. 1 Never Merried 2 Merried If yee, specify Cuben, Mexicen, Puerto Ricen, atc.)

1 YES 2 NO Specify: Specify: White В 3 X Widowed 4 Olvorced 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY E Elamentary/Secondery (0-12) College (1-4 or 5+) COMPL 9 Retail Clothing 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Surname Unknown Unknown Sarah BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Leonard Malamud 14411 Barkwood Dr. Rockville, Md. 20853 20 METHOO OF DISPOSITION 1 Burial 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE 4 Donetion 5 Other (Specify) Lebanon Cemetery 7/19/95 Adelphi, Md. 21. SIGNATURE OF FUNERAL SERVICE LA 22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 20852 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiretory arrest, shock, or heart fallure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onaat and Death disesse or condition LATERAL resulting in death) DUE TO (OR AS A CONSEQUENCE OF) MULTI-INF Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PERFORMEO? OF DEATH? 1 - YES 2 - 10 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO M UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OWHER: 1 Inputient 2 ER/Outputient 3 DOA Nursing Home 5 - Residence 8 - Other (Specify) 27. MATINER OF OEATH
Natural 5 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29e. CERTIFIER 1 (A) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(e) and manner ee stated. ation, in my opinion, death occured at the time, date end place, end due to the cause(e) end manner ee atated. 296. SIGNATURE AND FITLE OF CERTICIER 29c. LICENSE NUMBER hy sicion llending 1995 ny 80 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. GEGISTRAR'S SIGNATURE
Julia d'Auxilson Randall

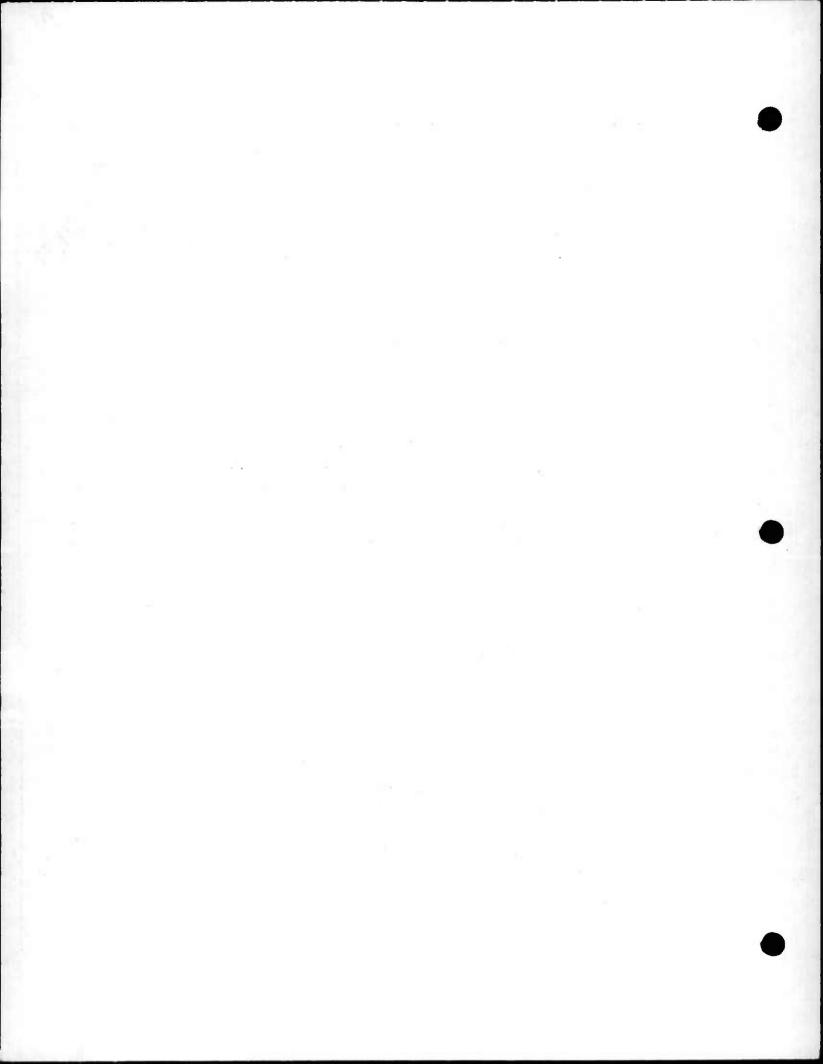
32. DEGISTRAR'S

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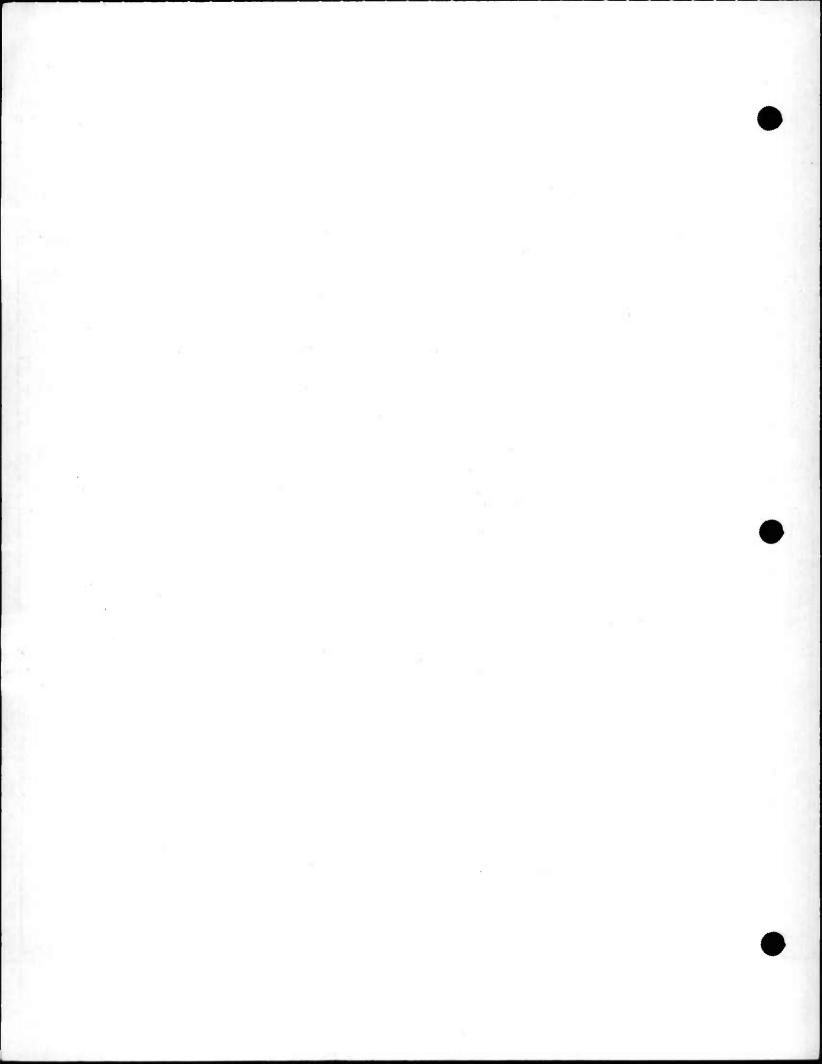
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Fage 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. MPORTANT: It item 28 is marked, or litem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
after death. Page 6 may be retained by the hospital or attending physicy the funeral director, page 5 should be detached for use as the burial. noval.	
AYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi its certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. """ """ """ """ """ """ """	
N: The law requires that the death ce icae has been signed by the attendit State Dept. of Health and Mental Hyy Item 23 shows any Injury, or or	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after of TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical e	

											9	5	23386
	1 - FOR STATE REGISTRAR		STATE OF I	MARYLAND	/ DEPAI	RTMENT	OF H	DEAT	AND ME	NTAL HYGIE			
	1. DECEDENT'S NAME (First Mabel		rginia	Мс	Dona1	d				DATE OF DEATH MONTH	DAY 7 19	95	3. TIME OF DEATH 11:30 PM
	4. SOCIAL SECURITY NUM 579-14-0023	BER	5. SEX	6. AGE (In yrs.	() YRS.	IF UNDER	DAYS	IF UNDER 2 HOURS	BANK	DATE OF BIRTH (Month, Day, Year) pt. 13, 19		8. BIRTI	IPLACE (State or Foreign
	9e, FACILITY NAME (If not in	nstitution, give s	street and number)			9b. CITY,	TOWN C	OR LOCATION			INTY OF E	st Virginia	
DIRECTOR	Wilson Hea	1th Ca	re Center	<u> </u>				rsbur				ntgo	
E C	RESIDENCE OF DEC	10b. COUNT	γ		10c. CITY, TOWN OR LOCATION							10d. INSIDE CITY	
	Maryland		gomery			thers					LIMITS?		
FUNERAL	10e. STREET AND NUMBER						101	. ZIP CODE			10g. CIT	IZEN OF	WHAT COUNTRY?
Ü	211 Russell Avenue Apt. 401						\perp		877			USA	
	11. MARITAL STATUS 1 Never Married 2	Married		YES 2	ARMED NO	13. W	AS DEC	ENDENT OF ocify Cuban,	HISPANIC , Maxican, F	ORIGIN? (Specify Yourio Rican, etc.)	ea or No—	14. RACI Blac	E — Americen Indian, k, White, atc.
B	3 🔀 Widowed 4 🗌 Divorced IF YES, GIVE WAR OR DATES					1	YES	2 📉 NO	Specify:			Spec	White
邑	15. DEC (Specify onl	EOENT'S EOU	CATION completed)	16a.	OECEDENT'S	USUAL OC	CUPATIO	ON of working		16b. KIND OF B	USINESS/IN	OUSTRY	
COMPLETED	Elementary/Secondary (College (1-4 or 5	•)	lile. Do NOT u	se retired.)	uning mo	si oi working	•		_		
M	17. FATHER'S NAME (First, M	fieldle (ant)		5	ales	Lady					.Penn	ey	
	Albert G. 1								ers name .e Cai	(First, Middle, Maide	n Sumame)		
BE	19a. INFORMANT'S NAME (T	19b. MAILING	ADDRESS	(Street e			Number, City or To	wn. Stein. 7i	n Codel	
2	Jean H. Ric	chards											895
	20a. METHOD OF OISPOSIT 1 🖾 Burlai 2 🗌 Cremetic	ION	ovel from State	20b. PLAC	E AND DATE	AND DATE OF DISPOSITION /Name of OATE 20c. LOCATION — City of Town State					wn, State		
100	1 Donation 5 Other (Specify) Ft. Lincoln Cemetery 7/21/95 Brentwood, M										MD		
1	21. SIGNATURE OF HUNGRA	L SERVICE LIC	CONSEE //	1200							ral	Home	Inc
	Francis J. Collins Funeral Home, 500 University Blvd.W. Sil.Spr.MD												
	23. PART I. Enter the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, such as cardiec or reepiratory arrest, shock, or heert failure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition reculting in death) • Carcinoma of Stomach DUE TO (OR AS A CONSCOURNCE OF):										Approximate Interval Between Onset and Death Month		
CERTIFICATION	If sny, leading to Imme- cause. Enter UNDERLY! CAUSE (Disease or Inju- thet initiated events	Sequentially list conditions, If smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury c											
MEDICAL (PART II. Other significe Complete			deeth but no	t resulting	In the und	lerlying	ceuse giv	ven in Par	PERFO	RMED?	24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE
AED										_ 1 TYES	2 🔯 NO		OF DEATH?
ä	DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF DE	ATH YE	S 🗆 N	0 🖾	UNCE	RTAIN				TES 2 KG NO
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:		ACE OF OEA	TH (Check on	nly one)						
YSI	1 TES 2 NO		1 Inpatient 2	ER/Outpatient	3 🗆 DOA	OTHER:		5 🗆 Resid	Idence 6	Other (Specify)			
표	27. MANNER OF OEATH 1 X Natural 5	Pending	28a. OATE OF (Month, Di		28b. TIM	URY	8c. INJU	JRY AT RK?	28	d. DESCRIBE HOW	INJURY OC	CURED	
B	2 Accident	Investigation	28e PLACE O	E IN HIEW AL		M		ES 2 🗌 I					
9		Could not be determined	building,	F INJURY — At atc. (Specify)	nome, rarm,	street, factor	ry, office	1	28	f. LOCATION (Street City or Town, State	and Number	or Rural F	Route Number,
COMPLETED			CIAN: To the best of) and manner as stated.
	296. SIGNATURE AND TITLE	-		200	1		T	29c, LICENS					
BE	Son 1	N	ha	141	/				0516				(Month, Day, Year) 17, 1995
2	39 HAME AND ADDRESS OF	PERSON WH	O COMPLETEO CAUS	E OF DEATH (IT	ЕМ 27) (Туре,	Print)		2 2	3310		L '	иту	11, 1995
	Joel R. Schu		M.D. 9	410 01	d Geo	rgeto	wn l	Road,	Beth	esda, M	208	814	
	JUL 21 19	95 Ja	31 REGISTRA	A STANFAIR									



			FOR 1 - STATE REGISTRAR	STATE OF M	IARYLAND C	/ DEPAR	RTMENT OF	HEALTH /	AND MEI		GIENE G. NO.				
			1. DECEDENT'S NAME (First, Middle, Last)							DATE OF DE	ATH DAY	YEAR	3. TIME	F DEATH	
			Marian 4. SOCIAL SECURITY NUMBER	Lucille		McGr	7	-	J	uly	20	1995	9:4		
			218-52-5535	5. SEX	6. AGE (In yrs. In	est birthday) YRS.	MONTHS DAYS		MIN.	Month, Day.	Year)	Cour	THPLACE (St ntry)	ate or Foreig	m
3	8		9a. FACILITY NAME (If not institution, give :							ug. 2	4,1949		yland		
S. should		<u>بر</u>	15532 Baileys La									COUNTY OF			
2	:	5	RESIDENCE OF DECEDENT				HE CAN SHOW	er Spr	ing		I M	lontgo	mery		_
Page		DIRECTOR	Money 1 and 1	•			TY, TOWN OR LO						10d, INSI LIMI	DE CITY	
Pages		AL D	Maryland Mo	ontgomery		Silver Spring								2 🔀 NO	
		ERA	15532 Baileys Lar	16		2090					10g.	CITIZEN OF		NTRY7	
15-0020 ending physician. as the burial-transit		FUN	11. MARITAL STATUS	12. WAS DECEDENT			13. WAS D	ECENDENT OF		RIGIN? (Spe	city Yes or No	— 14. BA	USA 14. RACE — American Indian,		_
Don's		BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1	YES 2 X	NO	If yes,	specify Cuben, ES 2 X NO	Mexican, Pu	erto Ricen,	etc.)	Bia	ck, White, e	c.	
215-0 attending		ED B												hite	
		ETE	15. DECEDENT'S EDU (Specify only highest grade	completed)		Give kind of the DO NOT u	WORK done during	TION most of working		16b. KIND	OF BUSINESS	S/INDUSTRY			
ND 2 hospital		P	Elementary/Secondary (0-12)	College (1-4 or 5+)) =		ng Co-on	rdinato	ar.	ъ,	rintin	-			
Q 9 9	once	COMPL	17. FATHER'S NAME (First, Middle, Last)			111011	.6 00 0.				Maiden Sumer	_			_
Z & 2	ਜ	ш	John Lorenz					Ire	ene Sa	undei	rs				
MAR retained 5 should	notified	TO B	19a. INFORMANT'S NAME (Type/Print)		11	9b. MAILING	ADDRESS (Street	t and Number o	r Rural Route	Number, City	or Town, State	e, Zip Code)			_
			Mary Kammerer			1130	Hornel:	l Drive	e, Sil	ver S	Spring	, MD	20905		
MORE, age 6 may be director, page	must	19 19	20e. METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Rem	oval from State			OF DISPOSITION		7 /0		20c. LOCATION				
ALTIMOR death. Page 6 ma funeral director, 5	je.		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	CENTRE	Gate	OI H	eaven (ANO ADDRESS	y //2	4/95 <u> </u>	Silve	r Spri	ing, 1	<u> </u>	
BALT ter death. the funera	eaun. rag tuneral di cuminer		V7//. / /	1//	16.00		Fran	ncis J.	Coll	ins E	unera.	1 Home	e, In	2.	
		-	23. PART 1. Enter the diseases, or	110	ueur	_	500	Univer	sity	Blvd.	W. Si	1.Spr	MD 2	0901	
S .E	2 2		snock, or neart failure.	List only one ceus	se on each lin	ieetn. Do i	not enter the n	node of dylni	g, auch aa	cerdiec o	r reapiretory	/ arreat,	Inte	roximate rval Betw	
% ≡	the the	- 4	disease or condition	Meta	etatic	Bros	st Cano	0.16					i .	et and D	eath
within mpletely	event,	ı	resulting in death)		OR AS A CONSE			.er					4	Mos.	
executed want comp		Z	Sequentially list conditions,	b											
O be ex	rior to buri	CATION	If any, leading to immediate cause. Enter UNDERLYING												
ficate physic	other tr		CAUSE (Disease or Injury thet initiated events DUE TO (OR AS A CONSEQUENCE OF):												
death certificate	I b	ERTIFIC	resulting in death) LAST												
he death	Tage >	O	DART II Other elevisions are distri-	u	need the								_		7-
4 2 6	× 5	8	PART ii. Other eignificent condition	e contributing to (deeth but not	reculting	In the underly	ng cause giv	ven in Part	1. 24a. V	MAS AN AUTOP PERFORMED?	PSY 24	b. WERE AUT	PRIOR TO	
puires the	of Health	MEDIC								1 🗆	YES 2 X NO	D	OF DEATH	ON DF CAUS	E
L KECC law requires as been sign	5 4	Σ	DID TOBACCO USE CONT	PIRLITE TO CAL	ISE OF DE	ATH VI	S D NO		DTAINL E	,		- 1	1 TYES	2 NO	
	8 B	NA:	25. WAS CASE REFERRED TO MEDICAL	KIDOTE TO CAC			TH (Check only on		KIAIN	- 1					_
F VIII.	or item	Sic	EXAMINER? 1 YES 2 XNO	HOSPITAL: 1 Inpatient 2	ER/Outpatient	3 🗆 DOA	OTHER:	ome 5 🗵 Resid	dence 8 🗆	Other (Speci	(fy)				
TYSIC is cer	with the	PHYSICI	27. MANNER OF DEATH	28e. DATE OF I (Month, Da	NJURY y, Ybar)	28b. TIM	E OF 28c. I	NJURY AT VORK?			HOW INJURY	OCCURED			
NG PI	_ = 1	B	1 Netural 5 Pending 2 Accident Investigation					YES 2	NO						
JEND! OF A	1 m		3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF building, e	INJURY — At he itc. (Specify)	ome, farm, :	street, Inctory, of	lice	281.	City or Town	(Street end Nur , State)	mber or Rural	Route Number	Μ,	
DR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate in	hours a	COMPLET	29e. CERTIFIER												
4 4	2 =	MP	(Check only one) 1 CERTIFYING PHYSI (Check only one) 2 MEDICAL EXAMINE												
TO THE HOSPITAL TO THE FUNERAL	Withir	- 14	2/H SIGNATURE AND TITLE OF CENTIFIES				on, in my opinion,			date end pi					
至 第	APOR	B	ame Ita	dul	1			カスー	SE NUMBER	36	29d.	DATE SIGNE	O (Month, Da	199	
F 5	≥ ≅	2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE	E OF DEATH (ITE	EM 27) (Type,	, Print)	00	10	, ~	1,4	1 7	00	(1)	
			Carolyn B. Hendri					reet. F	Kensi	neton	, MD	20895			
			31. DATE FILED (Month, Day, Year)	32 PEGISTRAR	'S SANATURE					70011	,	_00/5			_
	Ĺ		JUL 21 1995 8	with the same of the											
			*										n n	HAMM TO DA	



1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

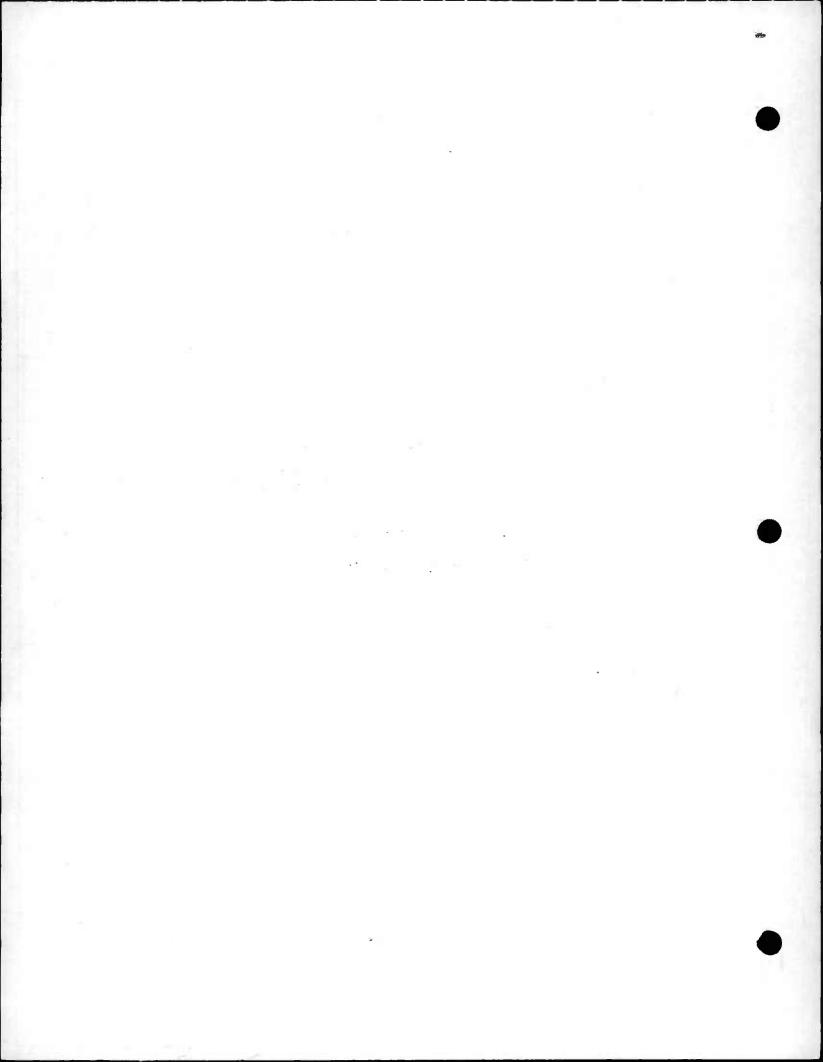
		4 DECEMBER 18 HARE (E)					10/11/					EG. NO.			
		1. DECEDENT'S NAME (Firs	7-72-	,	(E)(I)(I)(I)(I)						2. DATE OF (DA		YEAR	3. TIME OF DEATH
	1	4. SOCIAL SECURITY NUM	FFERY	5. SEX	ETTGER						JULY 12, 1995		7 7 7	3:50 P M	
	CTOR	218-82-938		1 ₩ 2 ☐ F	6. AGE (In yrs. la:	st birthday) YRS.	IF UNDER	1 YEAR DAYS	HOURS	MIN.	7. DATE OF E (Month, De	y, Year)		6. BIRTHI Country	PLACE (State or Foreign y)
should		9a. FACILITY NAME (If not in		A	42	Tho.	Sh CITY	TOMAL	00 1 0047	011 05 05	MARCH	1 22			WASH. D.C.
60		LIACHTNOMONI ADMINISTRATION TO CONTRACT													
1, 2,		RESIDENCE OF DECEDENT									GOMERY				
Pages	DIRE	10a. STATE	10b. COUNT			10c, CI7	Y, TOWN C	R LOCA	TION						10d. INSIDE CITY LIMITS?
permit. F		MD.		VIGOMERY			SII	VER	SPR	ING					1 X YES 2 NO
	FUNERAL	10a. STREET AND NUMBER		NITT.				10	t. ZIP COD						HAT COUNTRY?
020 physician. burial-transit	N	405 HINS	ODALE (IT EVER IN U.S. AF		1			910				U.S.	
D20 physic burial		1 🔀 Never Married 2 🗌	Married	FORCES? 1	YES 2	NO		f yes, sp	ecify Cuba	ın, Maxicai	IC ORIGIN? (S _I 1, Puerto Ricer	pecify Yae n, atc.)	or No-	Black	— American Indian, White, atc.
9 5 5	B	3 Widowed 4 Div	besno	IF YES, GIVE Y	WAR OR DATES			YES	2 NO	Specify	:			Specif	y: WHITE
r attend use as	E C	15. DEC	CEOENT'S EOU	CATION COMPrieted	16a. DE	CEDENT'S	USUAL O	CUPATI	ON osl of workin		16b. KIN	D OF BUS	INESS/IND	USTRY	WILLEL
2 6 2	LET	Elementary/Secondary (College (1-4 or 5	1660	. Do NOT u	se retired.)	Juning III.	USI OF WORK	ng .					
AND the hospital detached for once.	COMPL	12				OFFIC	CE WC	RKE	R				OFFI	CE	
the hore detach	8	17. FATHER'S NAME (First, A		E3EEEATTY					18. MOTI		AE (First, Middle	a, Maiden S	Surname)		
ed by the old be o		H. PHILIP		ÆTTGER							ULA		BRUN		
MAR retained 5 should notified	2	190. INFORMANT'S NAME (משימ							loute Number, C				0
	1 1	20a. METHOD OF DISPOSIT		GER	20b.PLACE	_				, SA	N DIE				
IMORE, Page 6 may be al director, page ner must be		1 Donation Donation	on 3 🗆 Ram	oval from State	cametery cre	WEE R	ther place	MATY	ORY	7	DATE		IVER		27.14.10.1
Page al dire		21. SIGNATURE OF FUNERA			0.222	20,4074.40			ND ADDRE	SS OF FAC	ILITY	11	T A TOTA	Detro	2 PH/s
ALTIN death. Pag s funeral di s. examiner	Į į	1/1/11	11/4	rulle.	M.							29-			20910
		23. PART I. Enter tha d	9W	omplications the		00091	. W.	W .	CHAN	BERS	CO. I	NC.	SILV.	ER S.	PRING, MD.
hours after of in by the or remova		snock, or n	aert failure.	List only one car	he on sech line	aun. Do i	not anter	tne mo	ode or dy	ing, eucr	as cerdiec	or respir	etory arn	est,	Approximate Interval Between
E @ ∰ 2		IMMEDIATE CAUSE (Finel disease or condition resulting in death)													
ted within 24 completely fill (al, cremation, event, the		a. DUE TO (OR AS A CONSEQUENCE OF):													
2 2 5 - 6				. 5	EPSI		,								210000
K . c = =	임	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): CONCESTIVE HEART-FAILURE 2 WECKE													
	2	cause. Enter UNDERLY CAUSE (Disesse or Inju		c	ESPI	RTO	RY	177	ILUX	25					> WEEKS
ding phy Hygiene in other	造	that initiated events resulting in death) LAS		DUE TO	(OR AS A CONSE	QUENCE O	F): /	110	-00	6	- A 11 1	1.0 10	_		2 /
	CERTIFICATION	156 Harris Debagain		d	onge)	///	16	76	<td>11</td> <td>1116</td> <td>INC</td> <td></td> <td></td> <td>- wedge</td>	11	1116	INC			- wedge
	4 1	PART II. Other significa			daath but not i	resulting	in the un	dariyin	g cause g	given in i	Part I. 24a	. WAS AN A			WERE AUTOPSY FINDINGS
a de de de	18	1001	NN15	SYNE	ROMI	-					15	PERFORM			AMILABLE PRIOR TO COMPLETION OF CAUSE
quires than signed if Health a	W												1000	- 1	OF DEATH?
	ä	DID TOBACCO U	ISE CONTI	RIBUTE TO CA	USE OF DEA	TH YE	S 🗆 1	10 E	UNC	ERTAIN	I X				
	PHYSICIAN:	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL	HOSPITAL:	26. PLAC	E OF DEA	TH (Check of	_							
SICIAN: The certificate the State	YSI	1 TYES 2 NO		1 Inpatient 2	ER/Outpatient 3	□ DOA			10 5 □ Ra	sidenca	B C Other (Spe	ecify)			
NG PHYSIC frer this co sath with 1	H	27. MANNER OF DEATH	Pending	28a. DATE OF (Month, D		28b. TIM	E OF	WO	DRK?	. 1	28d. DESCRIB	BE HOW IN	JURY OCC	URED	
After death	BY	2 Accident	Investigation	28a BLACE C	E IN HIEV As he		M		YES 2	NO					
TTEND TTOR: /		3 Suicide 8 Homicide	Could not be determined	building,	F INJURY — At ho atc. (Specify)	me, tarm,	strant, Inct	ory, offic	•		28f. LOCATION City or Tox	N (Street an wn, State)	d Number	or Rural Ro	oute Number,
OR ATTENU DIRECTOR: hours after item 28 ls		29a. CERTIFIER	SS 25 N B					_							
対対な	COMPL	(Check only		CIAN: To the best of											
THE HOSPITAL THE FUNERAL filed within 72.	8				ABITITATION AND/OF	investigatio	en, in my o	pinion, a				place, and	dua to the	cause(a)	and manner as stated.
PORT THE	띪	296. SIGHATURE AND TITLE		X 1	1164	71			29c. LICE	NSE NUM	BER		29d. DATE	SIGNED	(Month, Day, Year)
2 2 3 3	유	30. NAME AND ADDRESS OF	F PERSON WH	O COMPLETED CALL	SE OF DEATH ATE	M 27) /5m	Print1		2 3	617	-		JU	ILYI	2,1443
		30. NAME AND ADDRESS OF THE PORT OF THE PROPERTY OF THE PROPERTY OF THE PORT O	ROLL	AVE. S	PUITE 3	80	,71	HKA	111	PA	QK	MA	RVI	Aut	120912
		31. DATE FILED (Month, Day	Year)	32. REGISTRA	R'S SIGNATURE	11	/ / /		NUT	//1/	///	+ 1/ 11	-16.	11/1	
		JULIT	1995	July d'au	whole words	Leb									

C 6 . .

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. TO BE COMPLETED BY FUNERAL DIBECTOR IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 -	FOR STATE REGISTRAR	STATE OF N			MENT OF I	HEALTH AND	MENTA	L HYGIEN	E		
1. D	DECEDENT'S NAME (First, Middle, Last)	e, Last)					3. TIME OF DEATH				
	Jean	Μ.		YY.	Varlou)	MONT		190	TS	1820 M
4. S	SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH		BIRTHP	LACE (State or Foreign
i –	215-38-4251	1 🗆 M 2 💢 F	90	YRS.	MONTHS DAYS	HOURS MIN.		th, Day, Year)		Country)	
9a.	FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, TOWN	OR LOCATION OF D		0, 19	9c. COUNT		n Carolina ATH
	Shady Grove Adve	Roc	kville			Mon					
RE	SIDENCE OF DECEDENT					MOL	regor	nery			
			TOWN OR LOCA					1	10d. INSIDE CITY LIMITS?		
None None Was						on, D.C.					1 ⊠ YES 2 □ NO
100.	COL-911 / C14411-C12-00				10	. ZIP COOE			10g. CITIZE	N OF WH	AT COUNTRY?
	4201 Butterwort					20016					States
- 11	Never Married 2 Married	12. WAS OECEDEN FORCES? 1	YES 2		13. WAS DEC	ENDENT OF HISPA ecify Cuban, Mexic	NIC ORIGI	N? (Specify Yes Rican, atc.)	or No-	6. RACE - Black,	- American Indian, White, atc.
11	Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1 TYES	2 € NO Speci	lty:			Specify:	
15. DECEDENT'S EDUCATION 164. DECEDENT'S USUAL OCCUPATION							161	. KINO OF BUS	INFSS/INDI IS	Whi	te
(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (Give kind of work done during most of working life. Do NOT use retired.)							J. KIND OF BU	MNESS/INDUS	o ini		
	and the second s	1	·	Audito	r			ni+ad (2+2+00	Cor	vernment
17. F	FATHER'S NAME (First, Middle, Last)					16. MOTHER'S N				GOV	/ernment
	Rufus Parsons						e Hei		,		
19a.	INFORMANT'S NAME (Type/Print)			19b. MAILING /	ADDRESS (Street a		_		n. State. Zio Ca	ode)	
The state of the s									3 22215		
20a. METHOD OF DISPOSITION 20b BLACE AND DATE OF DATE OF D											
4 0	Buriel 2 Cremation 3 Remo	oval from State	Mont.	cremetory or oth	Cremate	uly 15, orium, I	1995	Ro+1			yland
21. 5	SIGNATURE OF FUHERAL SERVICE LIC	ENSEE	1	<u>jomer</u>	22 NAME A	AD ADDRESS OF E	ACII ITV				
	· (1) 0	01-			Rober	t A. Pum	phrey	Fune	cal Ho	me/,	lisconsin
-	Delphon	Lewo		0202	Avenu	Bethes	da, i	Marylai	id 208	14-3	501
23.	PART i. Entar the diseases, or di ahock, or heart feliure.	complications that List only one ceu	caused tha	death. Do no ine.	t anter tha mo	de of dying, suc	ch es cen	diac or respi	ratory arrea	ıt,	Approximate interval Between
	MEDIATE CAUSE (Fine)	1	L:	11 0.							Onset and Death
	eese or condition	MAPU	1 aT Uz	mu	MUON	4					Y)ass c
		O DUE TO	OR AS A CON	SEQUENCE OF	-						Vac
Sec	quentially list conditions,	, run ku	wow	Ne	ocas						years
If a	iny, leading to immediate use. Enter UNDERLYING	DUE TO	OR AS A CON	SEOUENCE OF)	:						
CAI	USE (Disease or injury	DUE TO	OR AS A COM	SEOUENCE OF)							
	t initiated events uiting in deeth) LAST	552 101	On AS A COM	SECOLACE OF)	,						
		1									İ
PAF	RT II. Other significent condition	s contributing to	daeth but no	ot resulting in	the underlyin	g cause given in	Part i.	24a. WAS AN			VERE AUTOPSY FINOINGS
1 _	Planse ex	s contributing to						PERFOR	A	C	MAILABLE PRIOR TO COMPLETION OF CAUSE
	U	U					_	1 123 4	110		F DEATH?
0	DID TOBACCO USE CONTR	RIBUTE TO CAL	JSE OF DI	EATH YES	□ NO I	UNCERTAL	ΝП				_ 125 x 30 110
25. V	WAS CASE REFERRED TO MEDICAL				(Check only one)						
	EXAMINER?	HOSPITAL:	ER/Outpatient		OTHER:	e 5 🗆 Residence	B COthe	or (Specify)			
27. N	MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIME	OF 28c. INJ	URY AT		SCRIBE HOW II	JURY OCCUP	RED	
1 %	Natural 5 Pending	(Month, Da	y, rear)	INJU		PRK?	100,11200				-
3	Accident Investigation Suicide 8 Could not be	28a. PLACE OF	INJURY — At	home, farm, str	eet, factory, offic		28f. LOC	ATION (Street a	nd Number or	Rural Rou	ite Number,
4 Homicide datarmined building, stc. (Specify)											
	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and manner as stated.										
											and manner are stated
200	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SPENATURE AND TOTAL OFFICENCY FIER										
130	He Complete	.00.	M			29c. LICENSE NU	MBER		29d. DATE S	NED (A	fonth, Day, Year)
30 4	IAME AND ADDRESS OF BERCON WILL	COMPLETED ONLY	F 05 05000	754 57 5	V	~74.	77		Jul	4 13	11773
A	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)										
ALAN S. CHANACES ISLUS Shade Grow Rd Rockerlle Mel 25253											
1	JUI 17 1995	J. J. As	velsor A								
<u></u>	JUL 1 1393	java ava	N. Kerman	ardall							



Pages 1, 2, 3 should

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30. NA

4 Homicide

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or at	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filled within 72 hours after death with the State Dept. of Health and Mental Hybiene prior to burial, cemarion, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
G PHYSICIAL	ter this certified the sith with the	narked, or
ATTENDIN	ECTOR: After ster dea	n 28 is n
PITAL OR	ERAL DIR	T: It iten
TO THE HOS	TO THE FUNI be filed within	IMPORTAN

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH SANKAR MITRA 4:00 PM 1995 JULY 12 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign (Month, Day, Year) Sept. 3, DAYS 028-72-0454 TXXM 2 F 50 YRS. 1944 India 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Holy Cross Hospital DIRECTOR Silver Spring Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 YES 2 1 NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 11700 Old Columbia Pike #2104 20904 India 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 22 MO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 X NO Specify: 1 Never Married 2 Married B 3 Widowed 4 Divorced Asian COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) 12 Sales Clerk Department Store 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Sudhansu Mitra Bulu Rani H 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20878 2 Sabit K. Ghosh 5 Citrus Grove Court, North Potomac, Maryland 20a. METHOD OF DISPOSITION
1 Burlat 2X2 Cremation 3 Re
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 7/15/95) DATE 20c. LOCATION - City or Town, State Montgomery Crematorium, Inc. Bethesda, Maryland ROBERT A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 SIGNATURE OF FUNERAL SERVICE LICENSEE M00846 23. PART I/ Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ehock, or haert failure. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Final Onset and Death** Hemorrhage disease or condition resulting in death) Intra cerebral 4 days DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24a, WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\boxed{1}\) 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 [Vinpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending В 1 YES 2 NO 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, offica building, stc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 6 Could not be

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one)

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER

_	$\stackrel{\smile}{-}$						
ME	AND	ADDRESS	OF PERSON	WHO COMPLETED	CAUSE OF I	DEATH (ITEM 27) (T	me Print
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		M 1	410 h.	114 2011	1010	1211	

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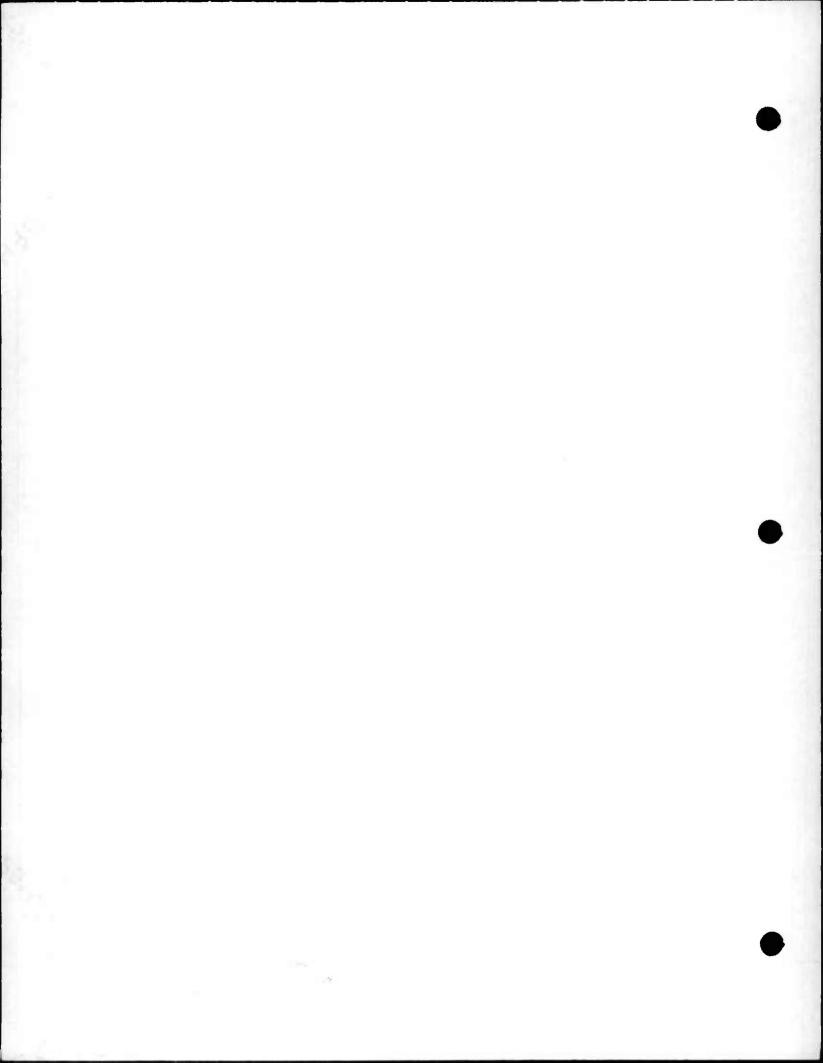
JULY 12 1995

31. DATE FILED (Month, Day, Year) 17 1995

determined

32. REGISTRAR'S SIGNATURE Davidson Ron

DHMH-16 Rev 1/89



3. TIME OF DEATN

2. DATE OF DEATH

FOR STATE REGISTRAR

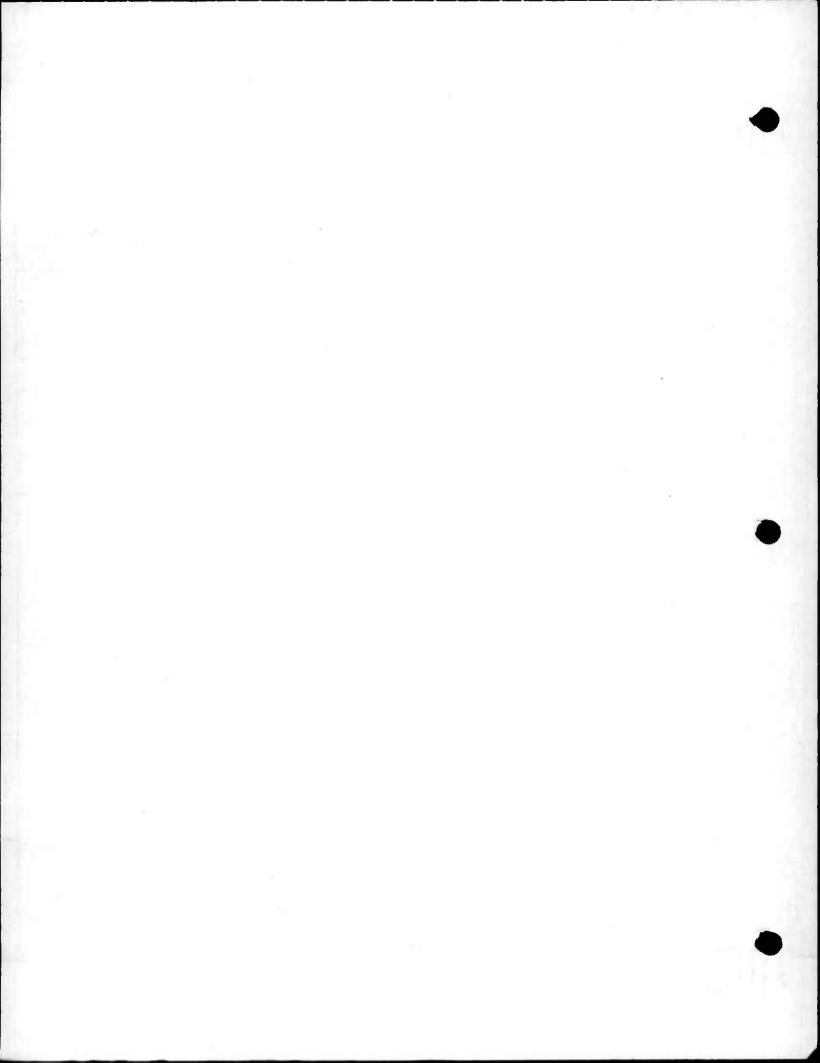
1. DECEDENT'S NAME (First Mickelle Last)

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John Garman Miller July 14, 1995 1:15 Ам 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTN (Month, Day, Year) 8. BIRTNPLACE (State or Foreign 1 M 2 F 178-32-0161 Jan. 25, 1938 Pennsylvania Pages 1, 2, 3 should Se. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 11904 Colin Road Wheaton Montgomery 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Wheaton Phours after death. Page 6 may be retained by the hospital or attending physician. Items in by the funeral director, page 5 should be detached for use as the burial-transit permit. 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 11904 Colin Road 20906 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2X NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Maxican, Puerto Ricen, atc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 K Merried В 1 YES 2X NO Specify: Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ive kind of work done Do NOT use retired.) ntary/Secondery (0-12) College (1-4 or 5+) 12 Animal Care Taker Federal Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) to John Joseph Miller Miriam Isabelle McGough BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Anita L. Miller 11904 Colin Road Wheaton, Maryland 20906 Pe 20s. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must 1 Sp Buriel 2 Cremellon 3 Removal from State
4 Donation 5 Other (Specify) Parklawn Cemetery 7/17/95 Rockville, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. Make filled in by the fillion, or removal. 500 University Blvd., W. Sil. Spr., MD 20901 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Final** Onset and Death cremation. event, the disease pr condition executed within completely resulting in death) . Metastatic Cancer of Colon 1 Year DUE TO (OR AS A CONSEQUENCE OF): burial. traumatic CERTIFICATION Liver Failure 2 Months and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): prior to If any, leading to immediate cause. Enter UNDERLYING physician 2 certificate CAUSE (Disease Dr Injury other Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated evants resulting in death) LAST attending 0 signed by the atter Health and Mental Injury, PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. he MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? that shows any 1 TYES 2X NO requires 1 TYES 2 NO peen 50 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DUNCERTAIN PHYSICIAN: Dept. * 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) **Tem** certificate HOSPITAL: OR ATTENDING PHYSICIAN: 1 TES 2 1 NO 1 🗆 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Nome 5 N Residence 6 Other (Specify) 28e. DATE OF INJURY the 27. MANNER OF DEATH 28c. INJURY AT 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED with marked. this 1 🔯 Natural 5 Pending В 1 YES 2 NO death 2 Accident DIRECTOR: At hours after de item 28 is n 3 🗌 Sulcide 28s. PLACE OF INJURY — At home, term, atreet, factory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED e Could not be 4 Homicide TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2 29a. CERTIFIER
(Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occured at the time, data end place, end due to the ceuse(e) end manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE En Hother D 17567 July 14,1995 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Cohen, 10215 Fernwood Road #402 Bethesda, Maryland 20817-1179 31. DATE FILED (Month, Day, 1997) 32. REGISTRAL'S SIGNOURES

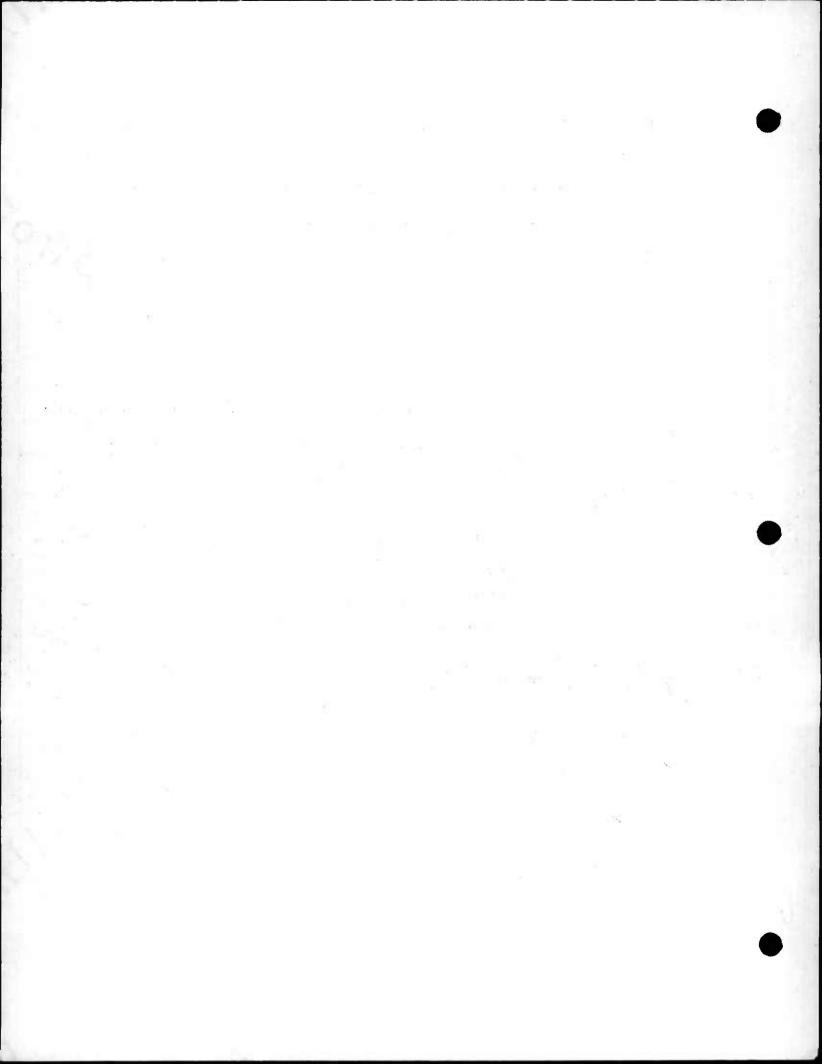
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



DIVISION OF VITAL RECORDS, P.O. BOX 68769

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withher withouts after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page be filled within 72 hours after death with the State Dept. or Health and Mental Hyglene prior to burial, cremation, or removal. INPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

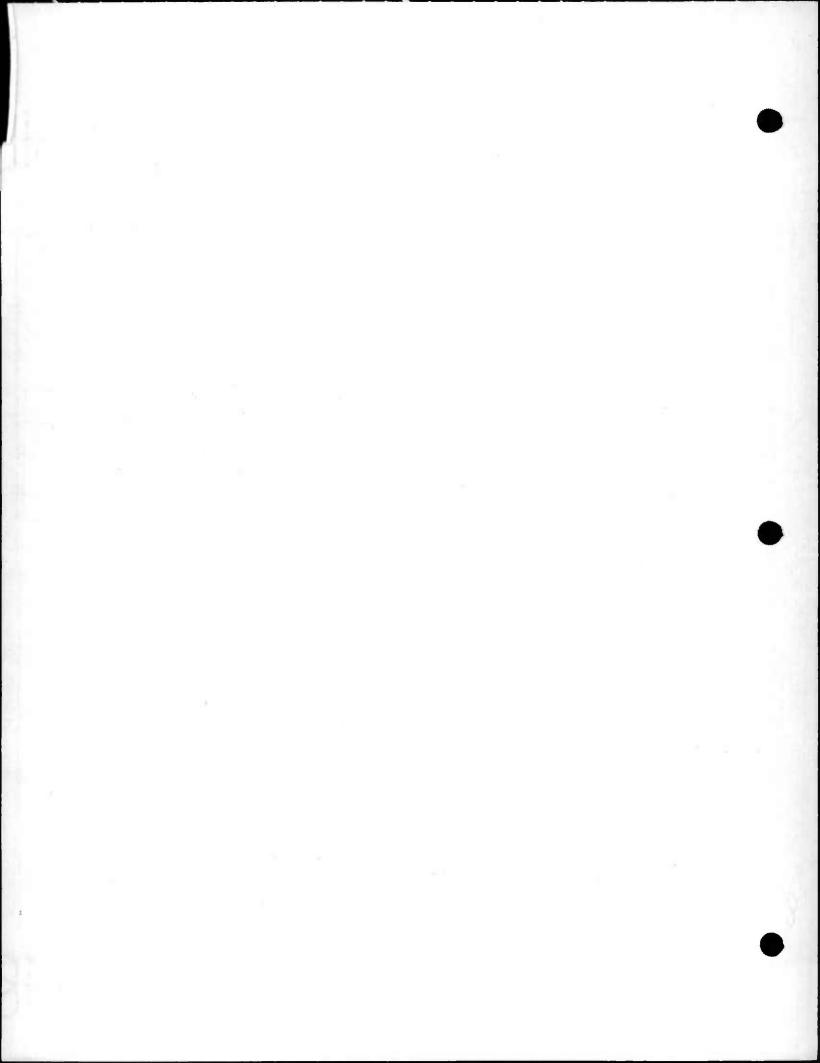
	1 - FOR STATE OF MARYLANI	D / DEPAR CERTIF	RTMENT OF	HEALTH AND F DEATH	MEN	TAL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH				3. TIME OF DEATH			
	AUBREY S. MUIR	50	٤.		ت ا	UL4	16,	1995	12:08 Am
3		s. last birthday)	IF UNDER 1 YEAR		7. D/	TE OF BIRTH	0.2.0	8. BIRTH Country	PLACE (State or Foreign
i ii	577-66-1269 1 🖾 M 2 🗆 F 62	YRS.	OL OUTY TOWN	1001001001001		1g. 21,1			
E	Washington Adventist Hospital			or Location of D a Park	DEATH		1 1 1 1 1 1 1 1	NTY OF D	
5	RESIDENCE OF DECEDENT						Mon	tgome	ery
IRE	Maryland Montgomery		Y, TOWN OR LOC						10d. INSIDE CITY LIMITS?
LD	Maryland Montgomery 10. STREET AND NUMBER	Tak	oma Par	'K IOT. ZIP CODE					1X YES 2 NO
ERA	7605 Wildwood Drive			20912			l		HAT COUNTRY?
FUNERAL DIRECTOR	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S	ARMED	13. WAS D	ECENDENT OF HISPA	NIC OR	IGIN? (Specify Yes	or No-		States - American Indian, , White, etc.
BY F	1 Never Married 2 X Merried FORCES? 1 YES 2 3 Wildowed 4 Divorced FORCES? 1 YES 2			specify Cuben, Maxico ES 2 X NO Speci		rto Ricen, etc.)		Black Specif	
		250525							ack
COMPLETED	(Specify only highest grade completed)	(Give kind of life. Do NOT u	CCEDENT'S USUAL OCCUPATION five kind of work done during most of working Do NOT use retired.)			16b. KIND OF BUS	SINESS/INC	DUSTRY	
1PL	Elementary/Secondary (0-12) College (1-4 or 5+)		untant			America	n Ri	vers	
Ö	17. FATHER'S NAME (First, Middle, Last)		-	18. MOTHER'S NA	AME (Fir	st, Middle, Maiden	Surname)		
BE (Samuel Muir			Albert	ta F	Rose			
0	19s. INFORMANT'S NAME (Type/Print) Jean Muir			t and Number or Rural					
				d Drive,			_		
	1 XBuriet 2 Cremation 3 Removat from State cemetery	crematory or o	of disposition (ther place) In Ceme		1			City or Tox	vn, State Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	BINCO	22. NAME	AND ADDRESS OF FA	ACILITY				
	MAYNIN Hath			ire Funer					20012
	23. PART I. Enter the diseases, or compilcations that caused the	death. Do r	not enter the m	Georgia	ch as c	erdiec or respi	was	ningt	Approximete
	IMMEDIATE CAUSE (Finel	line.					•		interval Between Onset and Death
	disease or condition	LARY	EMI	30205					10 min
	DUE TO (OR AS A COM	SEQUENCE O	F):						1
S S	Sequentially liet conditions, b. PARAP	ARES	[Comas
¥	if any, leading to immediate cause. Enter UNDERLYING								Q
Ē	that initiated events	SEQUENCE O	F):	THE P					0913
CERTIFICATION	resulting in death) LAST	N 23	ELLLIT	US (T41	AR	II)			2445
LC	PART II. Pather significant conditione contributing to death but n	ot resulting	in the underlyi	ng ceuse given in	Pert i	24s. WAS AN	AUTOPSY	24h	WERE AUTOPSY FINDINGS
ICAL	KENAL INSUFFICIENC					PERFOR	MEO?		AMILABLE PRIOR TO COMPLETION OF CAUSE
MED	PERINEAL INFECTION	1				1 TYES 2	NO	- 1	OF DEATH?
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF D	EATH YE	S I NO	UNCERTAI	N \square				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. P EXAMINER? HOSPITAL:	LACE OF DEAT	TH (Check only of	9)					
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	27. MANNER OF DEATH 1 Naturel 5 Pending 28e. DATE OF INJURY (Month, Day, Year)	28b. TIM INJ	URY	JURY AT	28d. I	DESCRIBE HOW IN	JURY OCC	CUREO	
B	2 Accident Investigation 3 Suicide 8 Could get be 28e. PLACE OF INJURY — A	t home ferm a		YES 2 NO	201	OCATION (Street a	and Alicenters	0 0	
COMPLETED	Suicide Could not be determined building, etc. (Specify)		ne, ferm, atreet, factory, office			Hy or Town, Stete)	na Number	or Hurai Ho	oute Number,
LE.	29e. CERTIFIER (Check only Check only Laboratorial Check on Check	. death occum	ed at the time, de	te and place, and due	to the	councie) and man		and .	
OME	(Check only one) 2 MEDICAL EXAMINER: On the beele of exemination end								end manner ee stated,
	296. SIGNATURE AND TITUE OF CERTIFIER	A	11:1-	29c. LICENSE NUI		. 1			(Month, Day, Year)
O BE	IT Noel (Beatlan, NA)	DHY	BILLIAN	D23	SIC	4	▶	0/- 1	6.1995
2	30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH ((ITEM 27) (Type,	Print)	N . A		1 -	_	1	0
	31. DATE FILEO (MONTH, Dgy, Year) J. REGISTBAR'S FIGNATION	HAM.	M.D.,	1610 CAF	ROI	LLAUE,	IAKO	MA	PARK, MO.
	JUL 19 1995	ardall				,			



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	3 should	~	9a. FACILITY NAME (# not in		treet end number)				
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	Sages	E	10a. STATE	10b. COUNT	/a			10c. C	
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	nsit per	FUNERAL DIRECTOR		anitol	Street,	NF			
Sician.		3	11. MARITAL STATUS	артсот	12. WAS DECEDENT	EVER IN U			
BALTIMORE, MARYLAND 21215-0020	ding physician. the burial-transit permit. Pages 1,	BY	1 1	ried 2 Merried FORCES? 1 IF YES, GIVE WAR					
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21	ital or att	COMPLETED	Elementary/Secondary (0		College (1-4 or 5 +	,	life.	ve kind o Do NOT	
S	the hospit detached once.	M M	12 17. FATHER'S NAME (First, M	iddle Leet)		1	Leg	<u>al</u>	
LA	be de	S	Patrick		nh				
AR	should should	BE .	190. INFORMANT'S NAME (7	Mur (ype/Print)	pity		196	. MAILI	
M	e 5 st	2	William L	. Mey	er			38	
RE.	may be		20e. METHOD OF DISPOSIT	ION			ACEA	NDDAT	
9	irecto		4 Donation 8 Other		DVIII Trom State	St.	ry, crer	natory or OSe]	
Ē	th. Pa eral d		21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE				
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hir 24 hours aft left filled in by nation, or remo	9	23. PART I. Enter the di	seesea, or o	omplications that	ceused th	ne de	eth. Do		
		IMMEDIATE CAUSE (Fir		List only one caus	se on eeci	n line.			
		disease or condition resulting in death)	→	Progress	ive (Cer	ebra		
760	ed wil	SICIAN: MEDICAL CERTIFICATION				OR AS A CO			
99	ertificate be executed within ing physician and completel iglene prior to burial, cremi other traumatic event,		Sequentially list conditi	ona,	Atherosc	clerot			
ŏ	sician prior t		If any, leading to immed cause. Enter UNDERLY	NG		0111010	,,,,,,,,	OLIVOL	
). B	g phy lene g	Ĭ	CAUSE (Disease or inju that initieted eventa		DUE TO (OR AS A CO	ONSEO	UENCE	
P. O	tendin al Hyg	ᇤ	resulting in death) LAS	T L	d				
VITAL RECORDS, P.O. BOX 68760	the deat y the ath nd Menta	C	PART II. Other algolifice	nt condition	s contributing to	death but	not re	sulting	
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ပ္က	been signe of Health								
æ	law requals been bept. of 23 she	z z	DID TOBACCO U	SE CONTI	RIBUTE TO CAL	JSE OF	DEA	rh Y	
Z	V: The kase cate has State De	CA	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26.	PLACI	E OF DE	
	CIAN: The prificate he State or Item		1 TES 2 NO		1 Inpatient 2	ER/Outpatle	ent 3	□ DOA	
OF	HYSIC his ce with t	PHY	27. MANNER OF OEATH 1 X Natural 5	Pending	28e. DATE OF ! (Month, Da			28b. Ti	
NO	After this cleath with marked	BY	2 Accident	investigation	28a PLACE OF	IN HIDV	41.500	4	
DIVISION OF	THE HOSPITAL OR ATTENDING PHYSICIA THE FUNERAL DIRECTOR: After this certified within 72 hours after death with the PORTANT: If item 28 is marked, or	BE COMPLETED		Could not be determined	28e. PLACE OF building, e	nc. (Specify)	At non	7e, term	
5	DIRE Pours	2	29e. CERTIFIER (Check only	IFYINO PHYSI	CIAN: To the best of r	ny knowled	ge, des	th occu	
	TO THE HOSPITAL TO THE FUNERAL De filed within 72 h IMPORTANT: It i	MO	one)		R: On the basis of ex				
	E FUI	EC	296. SIGNATURE AND TITLE	OF CERTIFIER	, -	7.6	_	_	
	는 무를 SM	10 B	Markan	reari	went	IM	10	0	
		F	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH	(ITEM	27) (Typ	
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_			31. DATE FILEO (Month, Day,		32. REGISTRAF	Aurelian	P	. 0 .	
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH YEAR <u>Helen</u> Murphy July 1995 PM 6:45 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) DAYS HOURS YRS. 94 May 5, 1901 New York 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Hyattsville Prince George's 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Washington, D.C. 1 TYES 2 NO 10g, CITIZEN OF WHAT COUNTRY? .E. 20003 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Maxicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: ER IN U.S. ARMED 14. RACE — American Indien, Black, White, atc. YES 2 € NO OR DATES Specify: White 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Legal Secretary Law 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Catherine Cahalin 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20003 1338 East Capitol Street, N.E. Washington, D.C. 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE St. Joseph's Cemetery 7/22/95 Yonkers, New York 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 bused the deeth. Do not enter the mode of dying, auch as cardiac or respiratory arrest, Approximata on each line. Interval Between **Onset and Death** ve Cerebral Thrombosis 24 Hours erotic Cardiovascular Disease Years AS A CONSEQUENCE OF AS A CONSEQUENCE OF th but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 21 NO 1 TYES 2 NO E OF DEATH YES INO INCERTAIN I 26. PLACE OF DEATH (Check only one) OTHER: Nursing Home 5 □ Residence 8 □ Other (Specify) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO JURY — At home, ferm, street, fectory, office (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) knowledge, death occurred at the time, data end place, end due to the cause(e) end manner ee stated. nation end/or investigation, in my opinion, death occured at the time, date end place, end dua to the ceuse(a) and menner as stated. 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) D 26331 July 17, 1995 F DEATH (ITEM 27) (Type, Print) 5401 MacArthur Boulevard, N.W. Washington, D.C. 20016



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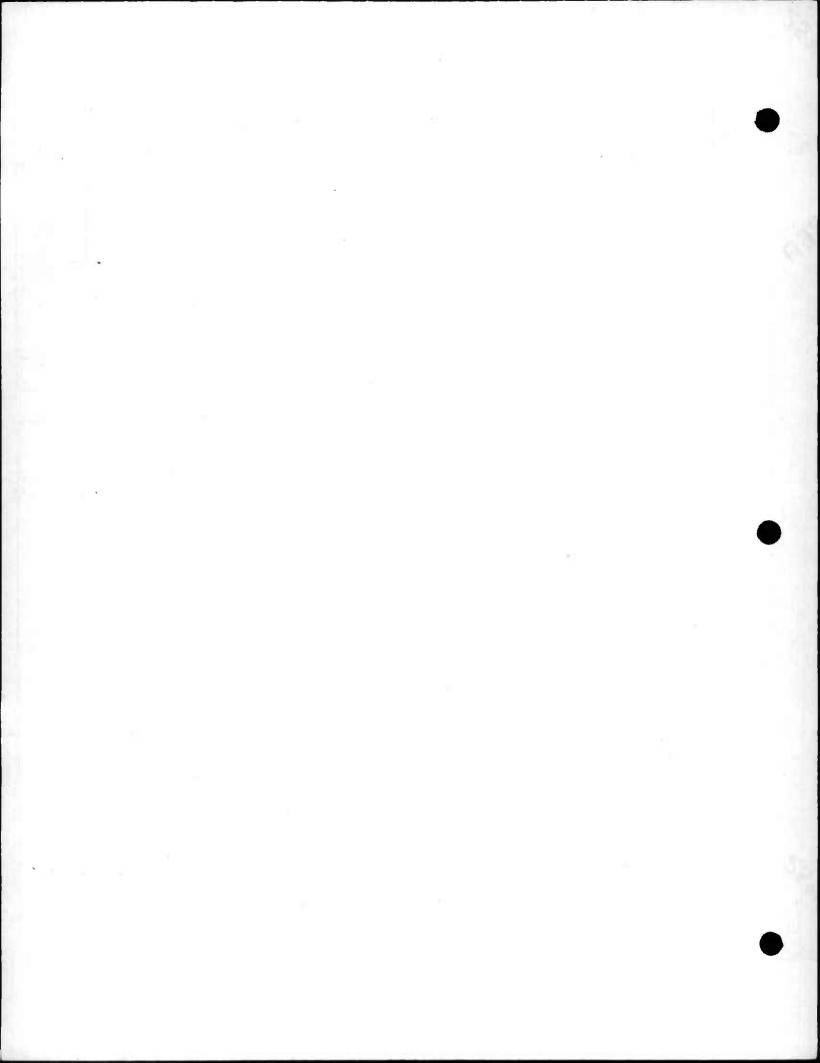
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ND MENTAL	HYGIENE	4	(0	u	n		9	

DIVISION OF VITAL RECORDS, P.O. BOX 68760	BALTIMORE, MARYLAND 21215-0020	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	ter death. Page 6 may be retained by the hospital or attending physician.	
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1 - 3 should	the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should	
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	yai.	
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	at examiner must be notified at once.	
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	TO BE COMPLETED BY FUNERAL DIRECTOR	

DIVISION OF

10a mended STATE OF MARYLAND / DEPARTMENT OF HEALTH A STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH 1995 MAX JÜLY 15, ALBERTO MARTINEZ 9:02 Ам 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. OATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign 1 X M 2 - F 216-31-3914 28 June 10, E1 Salvador 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATH 8020 14TH AVENUE #101 HYATTSVILLE PRINCE GEORGES RESIDENCE OF DECEDENT 10a STATE 18b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince George Hyattsville 1 K YES 2 NO 10a STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? Salvador 8020 14th Avenue 20783 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Maxican, Puario Rican, etc.) 1 YES 2 \(\subseteq NO \) Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 K Never Married 2 Married IF YES, GIVE WAR OR DATES Specify. 3 Widowed 4 Divorced El Salvadorian El Salvadorian 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Machine Opera 0 Construction Industry 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Antonio de Jesus Flores Emma Rodriguez 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jose M. Rodriguez 9235 Apartment M, Laurel, Maryland 20723 20a. METHOD OF DISPOSITION
1 Surial 2 □ Cremetton 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c, LOCATION — City or Town, State DATE camatery, crematory or other placa)
Cementerio de Asuncion Mita 4 Donation 5 Other (Specify) Mita, Guatemala 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave. Silver Spring 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Bstween IMMEDIATE CAUSE (Final Onset and Death disease or condition ela resulting in death) DUE TO (OFF AS A CONSEQUENCE OF Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, iseding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting In death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? ALCOHOL INTOXICATION YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 X YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT PH 28d. DESCRIBE HOW INJURY OCCURED Matural 1 YES 2 NO B 2 Accident Investigation 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town State) 6 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and menner as stated. 2XXMEDICAL EXAMINER: On the nination and/or investigation, in my opinion, death occured at the time, data and placa, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE O.C.M.E. ▶ JULY 16, 1995 2 DEATH (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF

MORE 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, 1987)
.] [] [18 1995



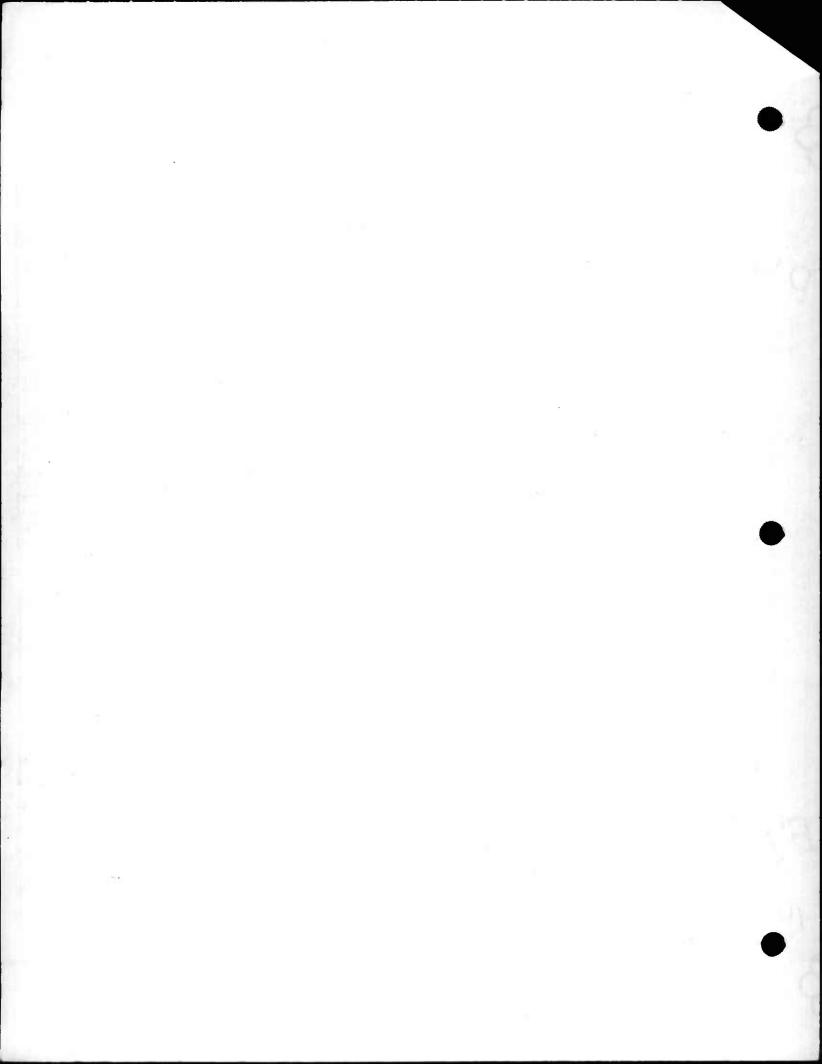
Pages 1, 2, 3 should

BOX 68760 BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit, be filled within 72 hours after death with the State Dept, of Heatth and Mental Hygiene prior to burial, cremation, or removal,	ir fraumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certific	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO 2. DATE DF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Leat) 3. TIME OF DEATH YEAR Gloria Macdonald 1995 July 17, 10:10 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. lest birthday) 5. SEX IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 M 2 F 094-24-8042 March 8,1930 New York Sa. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 9101 Providence Avenue Silver Spring Montgomery RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 TES 2 NO FUNERAL 10s. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 9101 Providence Avenue 20901 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Cuben, Maxican, Puarto Rican, etc.) 1 TYES 2 TO NO Specify: BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 16b. KIND DF BUSINESS/INDUSTRY (Specify only highes Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Aide Montgomery County 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Frank Marullo Anna Carcacappa BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 John R. Macdonald 9101 Providence Avenue Silver Spring,Maryland 20901 20a. METHOD OF DISPOSITION
1 (XBurial 2 | Cremation 3 | Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE Gate of Heave 4 Donation 5 Other (Specify) Heaven Cemetery 7/21/95Silver Spring, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. mothy 500 University Blvd.,W. Sil.Spr.,MD 20901 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximsta shock, or heert fellure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final Onset and Daeth disesse or condition UNG CANCER resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (DR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (DR AS A CONSEQUENCE OF): that initiated events resulting in dasth) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE PERFORMED? 1 TYES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL 1 YES 2 OTHER: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Rasidence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HDW INJURY OCCURED 1 Natural
2 Accident 5 Pending 1 YES 2 NO В Investigation 3 Suicide 28s. PLACE OF INJURY -- Al home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Homicide 29a. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: Do the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 🗌 MEDICAL EXAMINER: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) Danie 766 100 195 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE DF DEATH (ITEM 27) (Type, Print) Daniel Rosenblum, M.D. 10400 Connecticut Avenue Kensington, Maryland

36. REGISTRAR'S SIGNATUSE Fills DRUWLON RONDOLL



retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should **MARYLAND 21215-0020**

DIVISION OF VITAL

examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
al.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
he funeral director, page 5 should be detached	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache
ar death. Page 6 may be retained by the hos	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hos
BALLIMORE, MARYLANI	DIVISION OF VITAL RECORDS, P.O. BOX 88760

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	FOR STATE REGISTRAR	STATE OF MA					EALTH A			YGIEN	Ε		
DIRECTOR	1. DECEDENT'S NAME (First, Middle, Li Dr. Berl D. N 4. SOCIAL SECURITY NUMBER	Mendel	l. AGE (In yrs. le		IF UNDER		IF UNDER 24		2. DATE OF MONTH Jul	DEATH DA	, 1	995	3. TIME OF DEATH 5:26 P
	214-38-7913	i¥⊆ M 2 □ F	69	YRS.	MONTHS	DAYS	HOURS	MIN.	July	31,	1925	Countr	Canada
	98. FACILITY NAME (If not institution, give street and number) 99. CITY, TOWN OR LOCATION OF DEA 6205 Stardust Lane Bethesda RESIDENCE OF DECEMENT						ATH	9c. COUNTY OF DEATH Montgomery					
	10a. STATE 10b. COU				10c. CITY, TOWN OR LOCATION Bethesda								10d. INSIDE CITY LIMITS? 1 X YES 2 NO
IERAL	100. STREET AND NUMBER 6205 Stardust Lane 20817								10g. CIT	USA	VHAT COUNTRY?		
TO BE COMPLETED BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER I FORCES? 1 YES			RMED NO	- 1	If yes, spi	city Cuban,	HISPAN Mexicer Specify	IC ORIGIN? (S n, Puerto Rica	specify Yea n, etc.)	or No—	Black	— American Indian, c, White, atc. White
	15. DECEDENT'S I (Specify only highest g Elementary/Secondary (0-12)	College (1-4 or 5+)	16m. Di	16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Psychiatrist					EDIC		DUSTRY		
	17. FATHER'S NAME (First, Middle, Lest) David Mendel 18. MOTHER'S NAME (First Etta Feige									Sumame)	-		
	19a. INFORMANT'S NAME (Type/Print) Barbara Mendel		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 6205 Stardust Lane Bethesda, Md. 20817										
	20e. METHOD OF DISPOSITION 1						,	7/19/9			city or To	wn, State	
	21. SIGNATURE OF FUNERAL SERVICE CENTER 22. NAME AND AGORESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. 2085												
	23. PART i. Enter the diseases, shock, or heert fellu iMMEDIATE CAUSE (Finei disease or condition resulting in deeth)	s. Mex	on each ilns	entic	not enter	the mo	da of dying	, such	as cerdied	or respir	ratory are	rest,	Approximata interval Betwee Onset and Dea
ERTIFICATION	Sequentislly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d												
PHYSICIAN: MEDICAL CI	PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I.									PERFOR	MED?	24b.	WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
N: M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO TUNCERTAIN												1 YES 2 NO
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO												
РНҮ	27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) (Month, Day, Year)												

28a. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify)

1 YES 2 NO

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner ea stated. restigation, in my opinion, death occured at the time, data and pieca, and dua to the ceuse(a) and mennar as stated,

296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 12227

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. Fred Barr 106 Irving St. Washington, D.C.

31. DATE FILEO (Month, Day, Year)

JUL 20 1995

5 Pending

8 Could not be determined

1 Natural

2 Accident

3 Suicide

4 Homicide

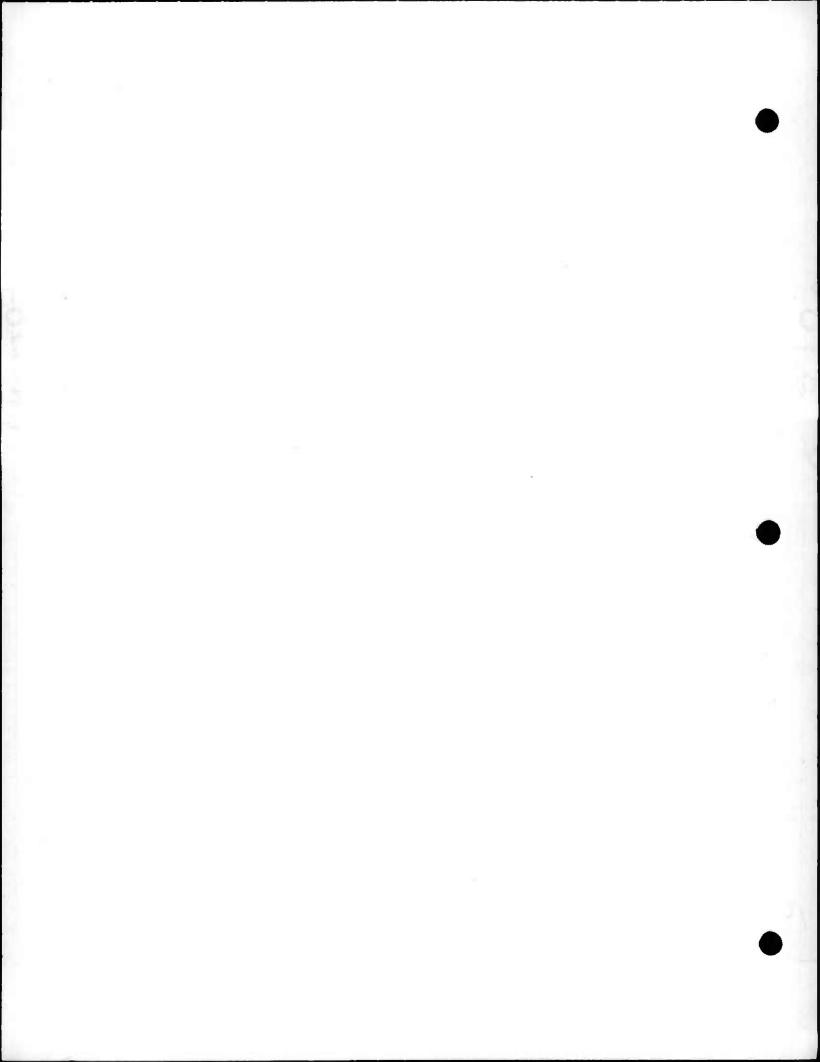
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal. MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH 3. TIME OF DEATH							
	GRACE VIOLET	MCKENZIE				JULY 21,	1995 ^{YE}	0330 A M			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (II		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. (BIRTHPLACE (State or Foreign			
	220-32-4847	1 🗆 M 2 💢 F	79 YRS. M	ONTHS DAYS	HOURS MIN.	Sept. 6,	1915	Country) Maryland			
	9a. FACILITY NAME (If not institution, give s	treet and number)	9	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							
6 R	Sacred Heart Hos	spital		Cun	berland		Allegany				
EG	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	Υ	10c. CITY	TOWN OR LOCAT	ION						
FUNERAL DIRECTOR	Maryland A			Frostbu	irg	10d. INSIDE CITY LIMITS? 1 MYES 2 NO					
	10e. STREET AND NUMBER		101	ZIP CODE	- 6	OF WHAT COUNTRY?					
	19 Howard Stree			21532		U.S.A.					
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPA	NIC ORIGIN? (Specify Ye	es or No. 14. RACE - American Indian.				
84	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA			2 RO Specif	an, Puarto Rican, etc.) fy:		Black, Whita, atc. Specify:			
	15. DECEDENT'S EDUC	CATION						White			
	(Specify only highest grade	completed)	(Give kind of wor life. Do NOT use i	k done durina ma	on st of working	16b. KIND OF BU	SINESS/INDUST	RY			
P	Elementary/Secondary (0-12)	College (1-4 or 5 +)		tress		Mar	nufactu	ring			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Maiden					
	Robert		Meese		Mar		,	lbright			
3 BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AI	ODRESS (Street a	nd Number or Rural	Route Number, City or Tow					
9	Jean Montana					Frostburg					
	20a METHOD OF DISPOSITION 1 December 1 December 2 Remove	oval from State	PLACE AND DATE OF	DISPOSITION (Na	me of	DATE 20c. LC	CATION - City	or Town, Stata			
	4 Donation 5 Other (Specify)	limi	nanuel Me	thodist	Cemeter	ry 7/23/95	Finzel	, Maryland			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	/	22. NAME AN	D ADDRESS OF FA	Durst F	uneral	Home			
	John K	Murit	-			ie Frostbui	rg, Md.	21532			
	23. PARP I. Enter the diseases, or o	complications that caused List only one cause on as	the death. Do not	antar the mo	da of dying, suc	h as cardiac or reap	iratory arreat,	Approximata			
	IMMEDIATE CAUSE (Fine)							Interval Between Onset and Death			
	disease or condition resulting in death)	· Jutr	a tob	to congestive Heart Friting 24ho							
į	IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions. Lutratible cangestive Hend Janhar Due to (or as a consequence of): Coronary Artery Przezy										
ON	Sequentially list conditions,	b. DUE TO COD AS A	consequence of:	HENDERSON Migray							
A	If sny, landing to immediate cause. Enter UNDERLYING	DOE TO (OR AS A	CONSEQUENCE OF):	QUENCE OF):							
FIC	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):	UENCE OF):							
CERTIFICATION	resulting in death) LAST	d.									
	PART II Other significant conditions contributing to death but not contile to the										
₹ B	PART II. Other eignificant conditions contributing to death but not reautiting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PRIORING AWAILABLE PRIOR TO COMPLETION OF CAUSE										
MEDIC	A	1				1 _ YES 2	₩ NO	COMPLETION OF CAUSE OF DEATH?			
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN										
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		8. PLACE OF DEATH		UNCERIAII						
SIC	EXAMINER?	HOSPITAL:	5 🗆 Booldones	8 Other (Specify)							
Ŧ	27. MANNER OF DEATH	28a. DATE DF INJURY	28b. TIME C	F 28c, INJ	JRY AT	28d. DESCRIBE HOW INJURY OCCURED					
ВУ Р	Natural 5 Pending 2 Accident Investigation				RK? ES 2 NO						
	3 Suicide 8 Could not be 28s. PLACE DF INJURY — At ho building, atc. (Specify)			et, factory, office		28t, LOCATION (Street and Number or Rural Route Number,					
COMPLETED	4 Homicide determined City or Town, State)										
PLE	29a. CERTIFIER (Check only Check only PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(s) and manner as stated.										
OM	one) 2 machical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.										
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUI	WBER	GNED (Month, Day, Year)					
	1 Ru				92124	~	7/22/5-				
2	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Pr	int)				(-(-),			
	JESUS TAN, M.D. EROSTBURG PLAZA FROSTBURG MD. 21532										
	31. DATÉ FILED (Month, Day, Year) JUL 24 1995										
	OOL 8 # 1999	The Signal Signal									

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	mit. Pages 1, 2, 3 should	
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours, after death with the State Dent of Health and Mental Numbers princ to harden common or removal	
after death. Page 6 may be ret	by the funeral director, page 5 s	TRACTICAL DESCRIPTION OF THE PROPERTY OF THE P
be executed within 24 hours	r this certificate has been signed by the attending physician and completely filled in by the following the State Dent of Health and Medal Hydiene prior to build cremation or removal	
ires that the death certificate	signed by the attending physic leath and Mental Hyniene pri	
3 PHYSICIAN: The law requi	ar this certificate has been sith with the State Dent of H	
HOSPITAL OR ATTENDING	TO THE FUNERAL DIRECTOR: After to be filed within 72 hours after death of	
THE CL	THE STATE	

	1 - STATE REGISTRAR	SIMIE OF	MARYLAND) / DEPAI Certif	RTMENT FICATE	T OF H E OF	IEALTH DEA	AND I	MENTA	L HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE	OF DEATH			3. TIME OF OEATH	
	JOHN LEDRUE	MCH	KINNEY						Jul		19	995	15:50	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	lest birthday)	IF UNDER		IF UNDER			OF BIRTH			LACE (State or Foreign	
	236-01-9396	1 🔀 M 2 🗆 F	79	YRS.	MONTHS	DAYS	HOURS	MIN.	Nov	. 2, 1	915		t Virgini	
E C	••. FACILITY NAME (If not institution, give Memorial Hospit						erla				NTY OF DE			
5	RESIDENCE OF DECEDENT							IIU				Alleg	any	
DIRECTOR				10c. Cl	ry, town o		TION						10d. INSIDE CITY LIMITS?	
	WV M:	neral			Keys		I. ZIP COD				T		T YES 2 X NO	
FUNERAL	Rt. 4, Box 240)				"					10g. CI1		IAT COUNTRY?	
Š	11. MARITAL STATUS	12. WAS DECEDER	NT EVER IN U.S.	ARMED	13.	WAS DEC	267		NIC OBIGI	N? (Specify Ye	a or No.	USA	- American Indian,	
	1 Never Married 2 Married	FORCES?	YES 2 [NO		If yes, sp	ecify Cube	in, Maxica	ın, Puerto	Rican, etc.)	- or 110	Black, Specify	White, atc.	
2 8	3 Widowed 4 Divorced		ld War				-A-A,	Opeon,	,			зреспу.	White	
3	15. DECEDENT'S EDI (Specify only highest grad		18a.	DECEDENT'S	work done a	CCUPATIO	ON est of working	ng	160	. KIND OF BU	ISINESS/IN	DUSTRY		
COMPLET	Elementary/Secondary (0-12) College (1-4 or 5+) ##e. Do NOT use retired.)													
	17. FATHER'S NAME (First, Middle, Last)			METO	GT			uenic		Plumbi		pefit	ting	
Ś	Dennis McKir	nev					_		, ,	Middle, Maider				
3	19a. INFORMANT'S NAME (Type/Print)			19b, MAILING	ADDRESS	S (Street -		ebec		Hende		n Corte		
2	Arda Bell McKinn	ev								WV				
	20a. METHOD OF DISPOSITION		20b. PLAC	CE AND DATE	OF DISPOS	SITION (Na							n, State	
	1 (X Buriel 2 Cremetion 3 Removal from State 2 Commander, cremetary, cremetary or other place) 4 Donation a Other (Specify) Potomac Memorial Gardens 1995 Keyser, WV													
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
	Rotruck-Smith Funeral Home 85 S. Main Street Keyser, WV 267 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,													
CENTINGO	interval Batween Onset and Death disease or condition resulting in death) Non Small Cell Lung Cancer OUE TO (OR AS A CONSEQUENCE OF): b. Due To (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF): Due To (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):													
	PERFORMED? 1 YES 2 NO OF D											/ERE AUTOPSY FINDIN MAILABLE PRIOR TO OMPLETION OF CAUSE OF DEATH? YES 2 NO		
SIGNA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PL	ACE OF DEA										
	1 TYES 2 NO	1 10 Inpatient 2		3 🗆 DOA	4 Num		o 5 □ Re	sidenca	6 🗆 Othe	er (Specify)				
	27. MANNER OF GEATH 1 Netural 5 Pending	28a. OATE OF (Month, L		28b, Till IN.	IE OF JURY	28c. INJ WO	URY AT RK?		26d. DE	SCRIBE HOW	INJURY OC	CURED		
	2 Accident Investigation	28, 21 10- 1	AP day of firms		М		/ES 2 [NO						
	3 Suicide 6 Could not be 4 Homicide determined	208. PLACE C building,	etc. (Specify)	nome, farm,	street, facto	ory, office			28f, LOC City	ATION (Street or Town, State)	and Number	r or Rural Rou	ite Number,	
	29a. CERTIFIER (Check only one) 1 T CERTIFYING PHYS	ICIAN: To the best of a											nd manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIE	R					29c. LICE	NSE NUN	BER		29d, DAT	E SIGNED (A	fonth, Day, Year)	
	WK						D	4349	7		17	118/9	5. (JULY 18	
	296. LICENSE NUMBER 296. LICENSE NUMBER D 43497 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
	Daniel Leibman M.		se of oeath (r rial Ho			ito	400	C11001-	0 m 1	nd Im				

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1	TO THE HDSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.
1	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit
	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

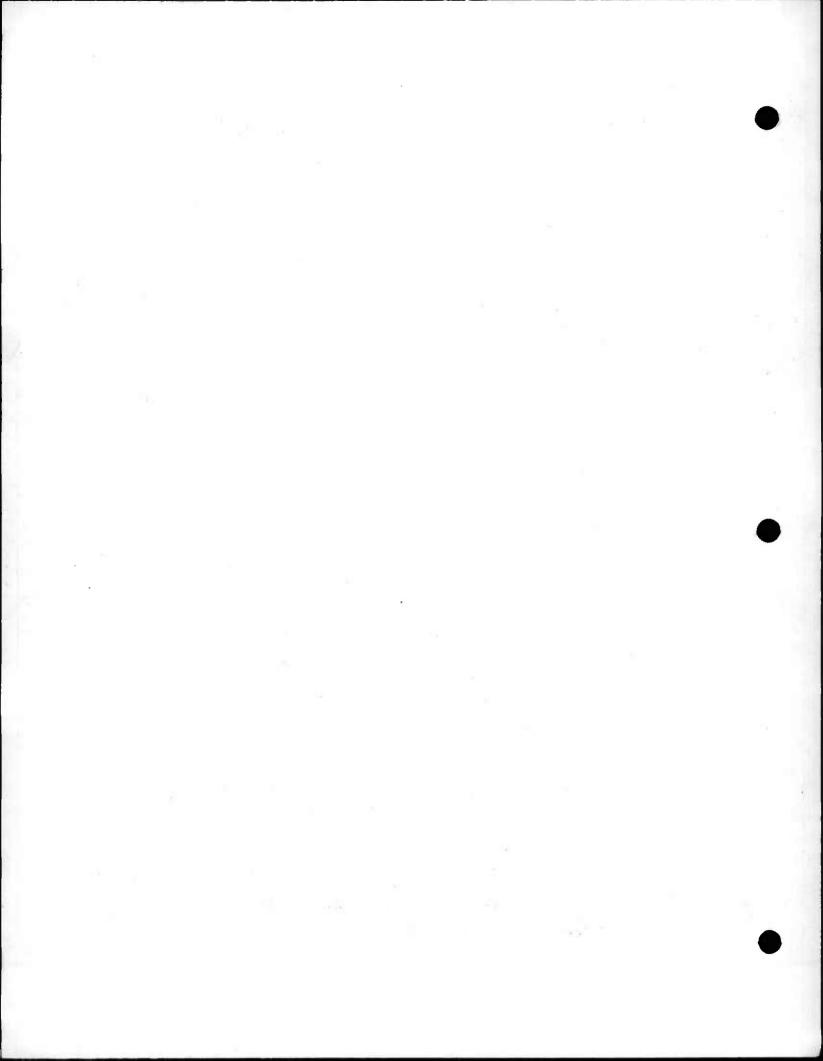
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH LAURA THELMA MCKENZIE JÜLŸ 18,1995 3:00 Рм 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year BIRTHPLACE (State or Foreign Country) 217-05-0439 HOURS 1 M 2 A 82 YRS. August 10 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Sacred Heart Hospital Cumberland **Allegany** RESIDENCE OF DECEDENT 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY Allegany Maryland Westernport 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 210 Riordan Road 21562 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 1 NO IF YES, GIVE WAR OR DATES? 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yea, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married ВҰ 1 TYES 2 THE NO Specify: Specify: 3 X Widowed 4 Divorced White COMPLETED 15. DECEOENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Homemaker Home notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) David Bothwell Grace Mott BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Thelma Matthews 210 Riordan Road, Westernport, Md. 21562 Pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE must 1 Donation 5 Other (Specify) Philos Cemetery 7-20+95 Westernport, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADORESS OF FACILITY
Boal Funeral Home 111 Church St. Westernport, Md. 21562 medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart failure. List only one cause on each line. intarval Batween IMMEDIATE CAUSE (Final Onsat and Death the disease or condition reaulting in death) event traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury that initiated evants reaulting in death) LAST PART II. Other significant conditions PHYSICIAN: MEDICAL SEA WAS AN AUTODOS 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 1 □ YES 2 DE DEATHS DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH 1 YES 2 NO YES NO 🖾 UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only ane) HOSPITAL:
1 Kingellent 2 - ER/Outpetient 3 - DOA T YES # NO OTHER: g Home S - Residence 6 - Other (Specify) 27. MANNER OF BEATH 28s. DATE OF INJURY (Month, Day, Year) JIIb. TIME OF 28c, INJURY AT WORKT 28d. DESCRIBE HOW INJURY OCCURED Natural M 1 YES 2 NO ВУ A Colden 28e. PLACE OF INJURY — At home, farm, street, factory, office building, sec. (Specify) 3 Suicide 60 29f. LOCATION (Street and Number or Pluret Route Number City or Town, State) 6 Could not be COMPLETED 4 Homicide 28 29a, CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the be instion and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. **MPORTANT**: 290. SIGNATURE AND TITLE OF GERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 5 9 COMPLETTO CAUSE OF OEATH (ITEM 27) (Type, Print)

> 90 MAIN STREET WESTERNPORT MD, 21562 2. REGISTRAD'S SIGNATURE

SHIN KIM, M.D.

JUL 21 1995

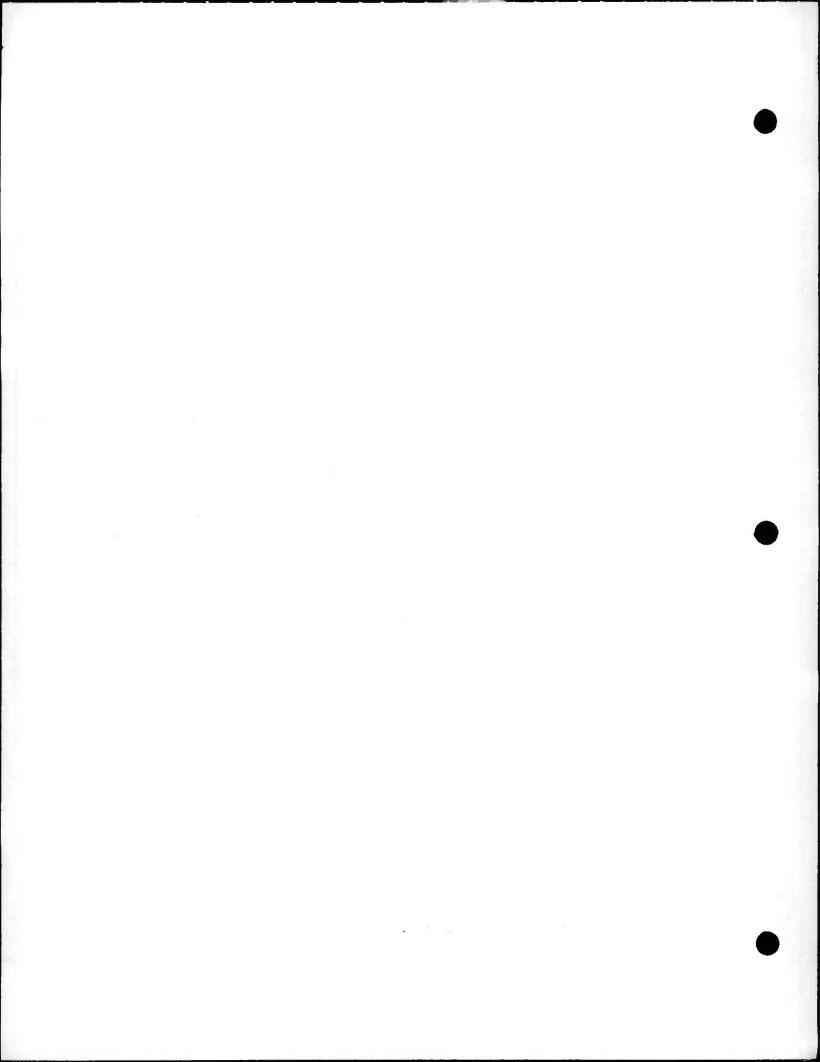
31. DATE FILED (Month, Day, Year)



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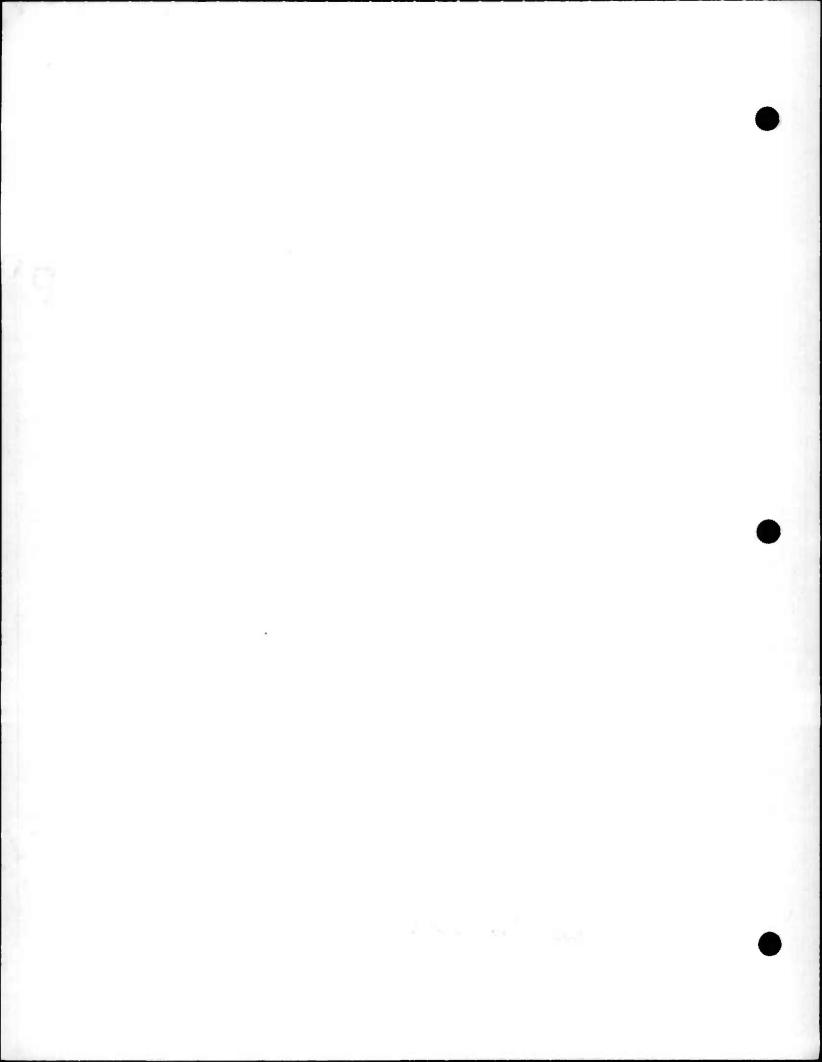
		1. DECEDENT'S NAME (First, Middle,	f most)												
											2. DATE MONTH	OF DEATH	AY .	YEAR	3. TIME OF DEATH
			·	Mc Na	aught	on					July		19	95	6:35 PM M
	1 1	4. SOCIAL SECURITY NUMBER	(in yrs. last	birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH		B. BIRTHE	PLACE (State or Foreign		
		418 12 5061	1 🗆 M 2 🔀	ĸ	76	YRS.	MONTHS	DAYS	HOURS	MIN.		Day, Year)	010	Country)
pino		9a. FACILITY NAME (If not institution,	give street and number				9h CITY	TOWN (OR LOCATI	ON OF DE		12,1			bama
3 should	Œ	96. CITY, TOWN OR LOCATION OF DEATH Crofton Convalescent Center Crofton Crofton Crofton Crofton Crofton Crofton													
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020 physician. burial-transit	l iii	1827 Foxdale C							2111	L4			Uni	ted	States
020 physician. burial-tra	FUN	11. MARITAL STATUS	12. WAS DECE	DENT EVER	IN U.S. ARM	MED	13.	MAS DEC	CENDENT C	F HISPAN	VIC ORIGIN	? (Specify Yea			- American Indian, White, atc.
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215-0 attending se as the		3 Widowed 4 Divorced						Λ		No			1	White	
use a		15. DECEDENT'S (Specify only highest	B EDUCATION grade completed)		16a, DEC	EDENT'S	USUAL O	CUPATIO	ON ast of working		16b.	KIND OF BUS	SINESS/IND	USTRY	
	[4]	Elementary/Secondary (0-12)	College (1-4 o	r 5 +)	life.	Do NOT us	e retired.)	ianny mo	ist or worker	g					
AND 2 the hospital detached to once.	COMPLET		2	,	C1e	rk						Cor	urt		
AND he hospii detached once.	S I	17. FATHER'S NAME (First, Middle, La.	st)		1 010				16 MOTE	JED'S NA	ME /First A	liddle, Maiden			
		T A11											Surrente)		
		Femster Alder 19a. INFORMANT'S NAME (Type/Print)		er				_				ilson			
retained 5 should					196.	MAILING	ADDRESS	(Street a	and Number	or Rural I	Route Numb	er, City or Town	n, State, Zip	Code)	
page 5		Ann M. Walkin	shaw		1	827	Foxd	ale	Cour	t C	rofto	n Md.	2111	4	
		20s. METHOD OF DISPOSITION 1 Derivated Burlet 2 Cremetion 3	Xamoval from State	200		ND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — C					City or Tow	rn, Stata			
) w # =	1 1	4 Donation 5 Other (Specify)			Elmwo			erv			1	Birmingham Alabama			
Page al direc		21. SIGNATURE OF FUNERAL SERVI	CE LICENSEE				22.	NAME A	ND AODRES						7.21 /-
death. P funeral	4	Kalat &	5	1	12							uneral			
after d after d by the moval.		mount c	· lan	3/-	16		1	<u> 5000</u>) Ann	apo1	is R	d. Bow	rie Mo	1. 20	715
		23. PART I. Enter the diseases	, or complicationaliure. List only one	that couse	d the dea	th. Do n	ot anter	tha mo	de of dy	ng, aucl	h ea card	lac or reapl	ratory arri	et,	Approximate
POE	1 1	IMMEDIATE CAUSE (Final	idio. List only one	ceuse on e	POCH HINE.			. 2			r	B-			Interval Between Onset and Desth
		disease or condition	The A	Com D	****	, d	reto	an	in 1	in	um	centr	4001	ulm.	/ / 0 -
ted within the completely fille ial, cremation, the event, the		IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Alarced suggestations are three fillulary of the consequence of:													10 reserv
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Ox 68/10 be be executed sician and con- rior to burial, traumatic en	CATION	Sequentially list conditions,	b. Dile	TO (OR AS	A CONSECU	IENCE OF	D.								
sician prior t	F	if any, laeding to immediate cause. Enter UNDERLYING		(A 00.10E01	DENCE OF	<i>y.</i>								
		CAUSE (Disease or injury	C. DUE	TO (OR AS	A CONSECU	IENCE OF									
	CERTIFI	that initiated events resulting in death) LAST		10 (011 A3 /	A CONSECU	JENCE OF):								
eath certi attending mai Hygie Y, or oth	浜		d												
E Se se	1 1	PART II. Other aignificant cond	ditione contributing	to death t	but not re	euitina i	n the un	deriving	COLLOG C	iven In	Part i	Part I. 24s. WAS AN AUTOPSY 24b			WERE AUTOPSY FINDINGS
T = 55 -	MEDICAL					/3	_		9 00000 8	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Tare I.	PERFOR		1 3	AVAILABLE PRIOR TO
uires tha signed Health a	ā		Rospino	young	pa	y	4					1 - YES 7	NO		COMPLETION OF CAUSE OF DEATH?
requires sen sign of Healt	×		COPI	2											1 TYES 2 NO
~ ~ ~	* * *	DID TOBACCO USE CO	ONTRIBUTE TO	CAUSE C	OF DEAT	H YE	1 🗆 2	10 🗵	UNC	ERTAIN	v 🗆 📗			1	'
ATTENDING PHYSICIAN: The law a Scribt: After this certificate has be a fater death with the State Dept. 128 is marked, or item 23 a	SICIAN	25. WAS CASE REFERRED TO MEDIC EXAMINER?			26. PLACE	OF DEAT		,,							
AN: Ifficat	S	1 TES 2/NO	HOSPITAL:		patient 3	DOA	OTHER 4 A Nurs	: Ina Hom	e 5 🗆 Re	aldenca	6 🗆 Other	(Specify)			
Sicia certificant the	PHY	27. MANNER OF DEATH	26a. DATE	OF INJURY		26b. TIME		28c. INJ		T		CRIBE HOW IN	MUBY OCC	URED	
		1 Natural 5 Pending		h, Day, Year)		INJ	JRY M	WO	RK?	ן מער	-50. 020			ONLO	
After death	B	2 Accident Investiga	28a PLAC	E OF INJURY	V At how					, NO					
OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	요	3 Suicide 6 Could no 4 Homicide determin	v na l Dalidi	ng, etc. (Spe	cify)	re, territ, a	HOUL, INCIC	ну, опис			City o	TION (Street a r Town, State)	nd Number (or Runal Ro	ute Number,
A AN	<u> </u>													_	
	립	(Check only 1 CERTIFYING	PHYSICIAN: To the bee	t of my know	viedge, dast	th occurre	d at the ti	ne, data	and place,	and dua	to the caus	e(a) and man	ner aa state	ıd.	
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A MIT WITH AN		296. SIGNATURE AND TITLE OF CER			-										
물 물 물 등	8	1 Si -D- /	attend .	06.		h			29c. LICE	NSE NUN	IBER - Z	/	29d. DATE	SIGNED (Month, Day, Year)
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<)		30 NAME AND ADDRESS OF PERSO	N WHO COMPLETED O	AUSE OF OE	EATH (ITEM	27) (Type,	Print)	1	.7	14.			7	7	
)/		1 and DALGS	m) 16	55	Cro	lon	BUN	1 n	ut,	101	Cu	Ken	me	121	1114
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		JUL 1919	195 July	an ameri		444									



FOR STATE REGISTRAR CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH 8 mo 39 4. SOCIAL SECURITY NUMBER 6. AGE (In vrs. lest birthday IF UNDER 24 HRS. IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Yea 8. BIRTNPLACE (State or Foreign 578-94-6658 1 X M 2 | F MONTHI DAYS 26 Nov. West Virginia Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR HOLY CROSS HOSPITAL Silver Spring Montgomery RESIDENCE OF DECEDENT 10a. STATE 16b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY PRINCE GEORGES Suitland permit. 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10a. CITIZEN OF WHAT COUNTRY? 4702 Bennett Avenue 20746 as the burial-transit USA hours after death. Page 6 may be retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or NoIf yes, specify Cuban, Mexican, Puerto Rican, stc.) 11. MARITAL STATUS 14. RACE — American Indian. Black, White, etc. If yes, specify Cuban, Mexican, Po 1 YES 2 NO Specify: 1 X Never Married 2 Married IF YES, DIVE WAR OR DATES B 3 Widowed 4 Divorced **Black** ETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY use (Specify only high funeral director, page 5 should be detached for entary/Secondary (0-12) College (1-4 or 5 +) COMPL 12 Sears Roebuck & Company Salesperson once. 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at William Holt Janette Dillard BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Janette Moslev 4702 Bennett Avenue, Suitland, MD must be 20a. METNOD OF DISPOSITION
1 ☐ Burlat 2 ☆ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 7/19 Alexandria, medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE MARSHALL'S Funeral Home, Inc. 4308 Suitland Rd., Suitland, MD 20746 and completely filled in by the or removal. 23. PART I. Enter the diseases, or complicatione that ceused the deeth. Do not enter the mode of dying, such as cardiec or raepiratory erreat, Approximate ehock, or heert feliure. Liet pnly one cause on eech lina. intervai Between IMMEDIATE CAUSE (Finel **Onset and Deeth** the cremation, diseese or condition eumo resulting in death) executed within event, Immune Deficiency Syndram burial, other traumatic CERTIFICATION Sequentially llat conditiona, DUE TO (OR AS A CONSEQUENCE OF): prior to t the attending physician Mental Hyglene prior to if any, leading to immediate cause. Enter UNDERLYING to pen CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST egg lovirus PART ii. Other aignificent conditions contributing to deeth but got resulting in the underlying cause givan in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS this certificate has been signed by with the State Dept, of Health and AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? any 1 TYES 2 NO 10 XOPIAS MOSIS 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES ☐ NO ☐ UNCERTAIN ☐ HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 □ Nursing Nome 5 □ Rasidence 8 □ Other (Specify) 1 YES 2 NO npetient 2 - ER/Outpetient 3 -0 27. MANNER OF BEATN 28a. DATE OF INJURY 286. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED marked. 1 Natural 1 YES 2 NO BY After 2 Acciden Investigation 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is COMPLETED 8 Could not be DIRECTOR: / 4 Nomicide tem 29a. CERTIFIER (Check only one) CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. FUNERAL I Ξ 2 MEDICAL EXAMINER: On TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II ation and/or investigation, in my opinion, death occured at the lime, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month), Day, Year) BE 8 9 30. NAME AND ADDRESS OF PER 31. DATE FILED (Month, Day, Year)

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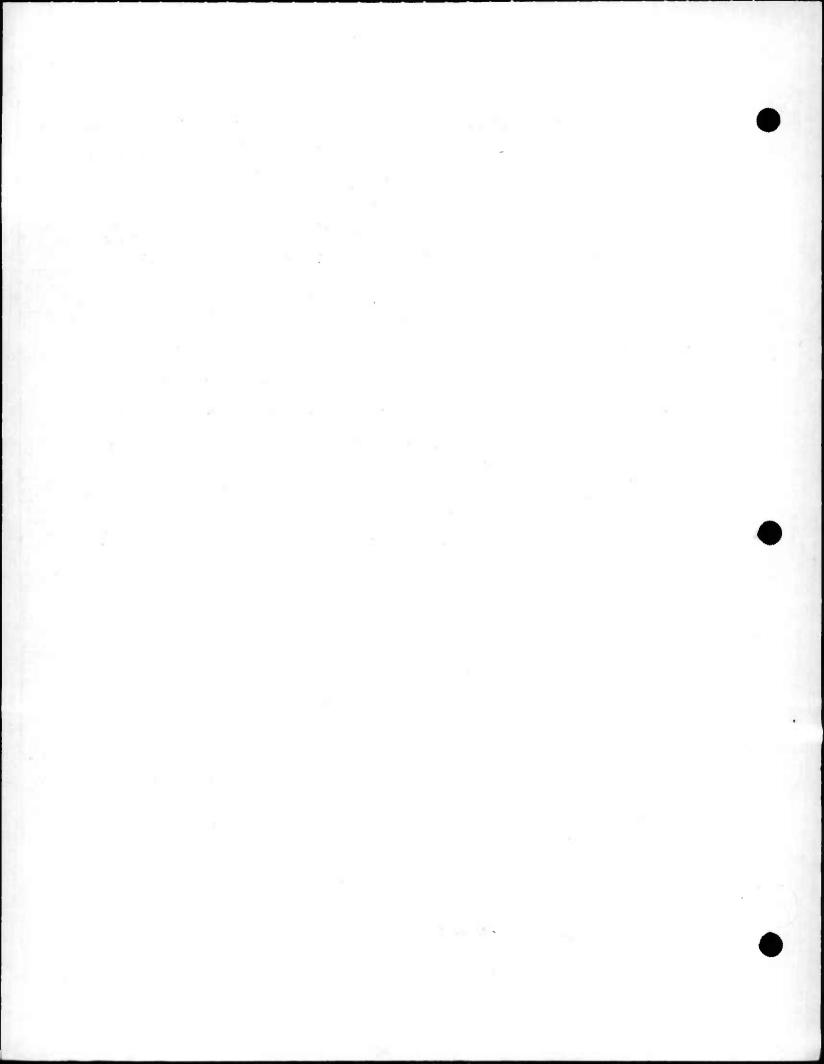
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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MARYLAND 21215-002	ted within 24 hours after death. Page 6 may be retained by the bosoits to after death.
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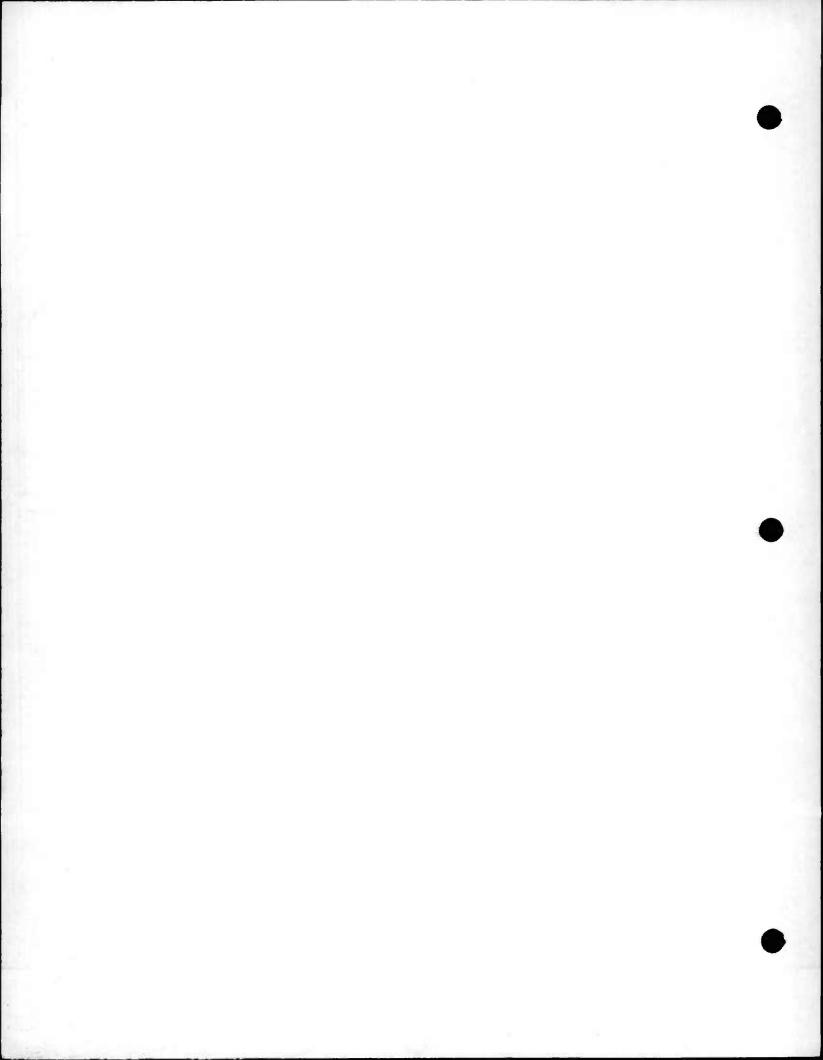
			1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF	HEALTH AND	MENTAL HYGIEN							
		3	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	MY Y	3. TIME OF DEATH					
		- 8	Herbert K. Ma				,	July 8	1995	7:45 P. M					
			4. SOCIAL SECURITY NUMBER	-99-	In yrs. lest birthday)	MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)					
	pino		577-38-4370 9a. FACILITY NAME (If not institution, give st	- 0	5 YRS.	AL OUTY TOWN	07.100.17.00.10.1	5/17/30		laryland					
	1, 2, 3 should	DIRECTOR	Presidential Wo		ng Home		or location of d phi	EATH	Princ	e George's					
	permit. Pages 1,	HE	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY					
	E.P	1	Md.	P.G.		Hyatts	ville			1 X YES 2 NO					
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AND	detached once.	COMPLETED	9th		Driv	er		Tract	or Tr	ailer					
LA			17. FATHER'S NAME (First, Middle, Last)	dagan				ME (First, Middle, Maiden	•						
A.	should be	ᇤ	Henry W. I	Mason ————				le Culle	4						
MARYL	5 should notified	입	Goldena Mason					Route Number, City or Tow	vn, State, Zip Co	de)					
шĨ ·	ay be		20e. METHOD OF DISPOSITION	201	Same as # 10 above DATE 20c. LOCATION — City or Town, State										
OR	ector, p		20b. NETHOD OF DISPOSITION 1X Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Neme of cemetery, crematory or other place) 1X Burlel 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, State A Donation 5 Other (Specify) Harmony Mem. Park 7/13/95 Landover, Md												
₹ .	al dire		21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	narmony	22. NAME A	Park //	13/95 La	ndove	r,Md.					
BALTIMORE,	nous and open. Page o may be ed in by the funeral director, page or removal. medical examiner must be r		23. PART I. Enter the diseases, Dr c			492	5 Burro	ngton & ughs Ave	., N.E						
RDS, P.O. BOX 68760,	at the usean continuate be executed writing and by the attending physician and completely fill and Mental Hygiene prior to burial, cremation y Injury, or other traumatic event, the	DICAL CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST	DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A	CONSEQUENCE OF	vary for Sussing and in the underlying	yricien urua g cause given in	rcy	AUTOPSY RMED?	Interval Between Onset and Death State Onset and Death State Onset					
REC	been signed t. of Health a	MEDIC	Mal IVW	returo				I I I I I I I I	X-XIIO	OF DEATH?					
æ	certificate has been signed in the State Dept. of Health if or Item 23 shows an	Z	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YE	S 🗆 NO 🗆	UNCERTAIL	<u> </u>		1 123 2 110					
VITAL	state Dept	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT	H (Check only one)									
5	or Ite	, Si		HOSPITAL: 1 Inpatient 2 ER/Output	ntient 3 🗆 DOA	OTHER:	e 5 🗆 Residence	8 Other (Specify)							
OF VI	this cer with th	PH	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIMI		URY AT	28d. DESCRIBE HOW I	NJURY OCCUR	ED					
Z		B¥	XXNetural 5 Pending 2 Accident Investigation			M 1 🗆	YES 2 NO								
DIVISION	TOR: A after d	9	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, atc. (Speci	— At home, ferm, a	treet, factory, offic		261. LOCATION (Street City or Town, State)	and Number or I	Bural Route Number,					
IQ MIGSON	로 경 전 =	COMPLE		IAN: To the best of my knowle : On the basis of examination						suse(a) end mennar as stated.					
5	THE FUNE filed within	BE C	290 SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI	ABER	29d. DATE SI	GNED (Month, Day, Year)					
F	는 를 교	D B	Muhapa	My			1)-37	1332	▶ J1	aly 11,1995					
M	>	F	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA			a Ave.,	silver S	220	Md.20902.					
7	1		31. DATE FILED (Month, Day, Year)	32. REGISTRAS'S SIGNA		-									

		1 - FOR STATE REGISTRAR	STATE OF MARYL								
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	FDEATH	3	3. TIME OF DEATH	
			AZITIS MACKNIS Sex A AGE (b) yrs. feet brinday FLADER YEAR PURCES 1 YEAR Dec C. 26, y 1915 C. 19		6-25 AM						
Pin		4. SOCIAL SECURITY NUMBER 178-01-7285	1 🗆 M 2 🖾 F 7		MONTHS DAYS	HOURS MIN.	Dec.		8. BIRTHPL Country) Conne	LACE (State or Foreign	
3 should	Œ	The same of the sa					DEATH				
1. 2,	6	RESIDENCE OF DECEDENT	ноте		Adelp	ni		Pr	ince G	eorge's	
permit. Pages 1	DIRECTOR	The second secon							1	0d. INSIDE CITY LIMITS?	
St	FUNERAL	100. STREET AND NUMBER 5019 Mineola Road			10			-	10g. CITIZEN OF WHAT COUNTRY?		
21215-0020 I or attending physician. For use as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	FORCES? 1 YES 2 NO If yes, specify Cuban, Me					14. RACE — Black, \ Specify:	- American Indian, white, etc. White	
r attend	윤	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	16a. DECEDENT'S	USUAL OCCUPATI	ON opt of working	16b. K	IND OF BUSINESS/IN	IDUSTRY		
tal or lifer u	COMPLETED	Elementary/Secondary (0-12)		life. Do NOT us	se retired.)	ost of working		_			
MARYLAND 2 retained by the hospital 5 should be detached to notified at once.	ఠ	12 17. FATHER'S NAME (First, Middle, Last)		Homema	ker						
YLA by the be de			aitic			1					
MAR) retained to 5 should	BE	19e. INFORMANT'S NAME (Type/Print)	11010	19b. MAILING	ADDRESS (Street			4			
ay be reta page 5 sl	2	Carol E. Macknis	200	5019 1	Mineola	Road, Co	11ege	Park, Ma	ryland		
TOR e 6 ma ector. p		1 Donation 5 Other (Specify)	over from State com-	etery, crematory or o	ther place)						
BALTIMORE, nours after death. Page 6 may be fol in by the funeral director, page or removal.		21. SIGNATURE OF FUNERAL SERVICE LIG			Franci	ND ADDRESS OF FA	s Son	s Funeral	Home	, P.A.	
B after y the noval		23. PART I. Enter the diverses, or o	omplications that caused	the death Do s	4/39 1	saltimore	Ave.	,Hyattsvi	lle, l		
F July		iMMEDIATE CAUSE (Final disease or condition	Liet only one ceuee on ee	ich line.			on ma cerdia	c or respiratory e	reat,	Approximate interval Between Onset and Death	
68760 eccuted within and and completely fill, burial, cremation, atic event, the		resulting in death)						· · · · · · · · · · · · · · · · · · ·		6 mans	
68 xecu and and bur	CERTIFICATION	Sequentially list conditions, if any, leading to immediate b. CHRONIC RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF):									
BOX ficate be physician ne prior t	FICA	CAUSE (Disease or injury			5ym						
G T B F P	ERTI	thet initiated events resulting in death) LAST								575.	
RDS, nat the deat by the atternal and Mental Ny Injury.		PART II. Other eignificent condition							24h W	ERE AUTOPSY FINDINGS	
RECORE requires that the been signed by the Health and shows any in	MEDICAL							PERFORMED?	AV CC	MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH?	
		DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF	F DEATH YE	S I NO D	UNCERTAL	N		1	YES 2 NO	
TA The	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		86. PLACE OF DEAT		1					
ICIAN ertific the S	ΥS	1 VES 2 NO 27. MANNER OF DEATH			Nursing Hon						
ON OF VI DING PHYSICIAN: After this certifica death with the St marked, or it	BY PH	Natural 5 Pending 2 Accident Investigation		286. TIMI	URY WO	DRK?	28d. DESCR	IBE HOW INJURY OC	CURED		
ISIC TTEND TOR: 4 after 6		3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, etc. (Speci	At home, farm, a	traet, factory, offic	•	28f. LOCATI City or	ON (Street and Number Town, State)	r or Rural Rout	te Number,	
DIV TO THE HOSPITAL OR A TO THE FUNERAL DIREC BE filed within 72 hours	COMPLETE									nd manner ee stated.	
E FU	шШ	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER	29d. DAT	TE SIGNED (M	lonth, Day, Year)	
TO THE De filed IMPOR	m	Le Le	Muni	0		D13 66	8	•	7-15-95		
2	٩							(arvland	20740)	
5)		31. DATE FILED (Month, Day, Year) JUL 19 1995	CERTIFICATE OF DEATH REG. NO. REAZITIS MACKNIS BRAZITIS MACKNIS BRAZITIS MACKNIS S. 19 3 20 7 79 79 19 10 10 10 10 10 10 10 10 10 10 10 10 10		,						
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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	ATTEN	CTOR
5	OH OH	띪
-	HDSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 n	FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director
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	1 - STATE REGISTRAR		D / DEPARTMENT	OF HEALTH AND ME	NTAL HYGIENI REG. NO.	E								
	1. DECEDENT'S NAME (First, Middle, Las 4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In)	yrs. last birthday) IF UNDE	1 YEAR IF UNDER 24 HRS. 7.	DATE OF DEATH MONTH DAT DATE OF BIRTH (Month, Day, Year)	91	3. TIME OF DEATH 2 1 0 0 INTERPLACE (State or Foreign							
OR	114-03-0313 9e. FACILITY NAME (If not institution, give HOLY CROSS HO	street end number)	9b. CIT	TOWN OR LOCATION OF DEATH	-	9c. COUNTY	POLAND OF DEATH GOMERY							
DIRECTOR	MARYLAND	MONTGOMERY	10c. CITY, TOWN ROCKV			10d. INSIDE CITY LIMITS? 1 YES 2 NO								
FUNERAL	100. STREET AND NUMBER 4212 INDEPEND. 11. MARITAL STATUS			10f. ZIP CODE 20853	UNITE	OF WHAT COUNTRY? D STATES								
ВУ	1 Never Married 2 Merried 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 YES	2 XNO	WAS DECENDENT OF HISPANIC (If yes, specify Cuban, Maxican, Pi I YES 2 NO Specify:			RACE — American Indian, Black, Whita, etc. Specify: WHITE							
COMPLETED	15. DECEDENT'S EL (Specify only highest gra Elementary/Secondary (0-12)	Coffege (1-4 or 5+)	Sa. DECEDENT'S USUAL Of (Give kind of work done life. Do NOT use retired.) MANAGER	CCUPATION during most of working	FILM IN		Y							
BE														
2	19e. INFORMANT'S NAME (Type/Print) FRAN OSCAR (DAUGHTER) 19b. MAILING ADDRESS (Street and Number or Bural Route Number, City or Town, State, Zip Code) 4212 INDEPENDENCE STREET - ROCKVILLE, M 20e, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION — City of Towns (State, Zip Code)													
	iMMEDIATE CAUSE (Final disease or condition	has	na daath. Do not entar		CIKE - RO	CKVILLI atory arrest,	APPELS, INC. E,MD. 20852 Approximate interval Betwee Onset and Dec							
ICAL CERTIFICATION	Sequentielly list conditions, if any, lasding to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CC	DISEQUENCY OF)	xtery y	25ca	(o	100							
MEDICAL (PART II. Other significant condition	ona contributing to death but	not rasuiting in tha ur	derlying cause given in Pari	i. 24s. WAS AN A PERFORM	MED?	24b. WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO							
	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26.	PLACE OF DEATH (Check											
TED BY PHYSICIAN	1 YES 2 NO 27. MANNER OF DEATH 1: Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined	HOSPITAL: 1 □ Inpettent ☑ ER/Outpette 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY — building, stc. (Specify)	28b. TIME OF INJURY	Ing Home 5 Realdence 6 28c. INJUSTY AT 28c. INJUSTY AT 28c. INC. YES 2 NO	Other (Specify) L-DESCRIBE HOW IN. LOCATION (Street an City or Town, Stete)									
O BE COMPLET	29a. CERTIFIER CERTIFYING PHY	SICIAN: To the best of my knowledg		me, date and place, end due to the										
TO BE CO		Beste	lun		dete and place, and	due to the cau 29d. DATE SIG								



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF OEATN 3. TIME OF DEATN LUIS FEDERICO NAVARRO YEAR July 14, 1995 8:30 AM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) NOV. 8, 5. SEX 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 579-54-8162 DAYS **₩X M 2** □ F 55 1939 Lima, Peru hours after death. Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 19121 Treadway Road Brookeville Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Montgomery **Brookeville** 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 19121 Treadway Road 20833 United States 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.)

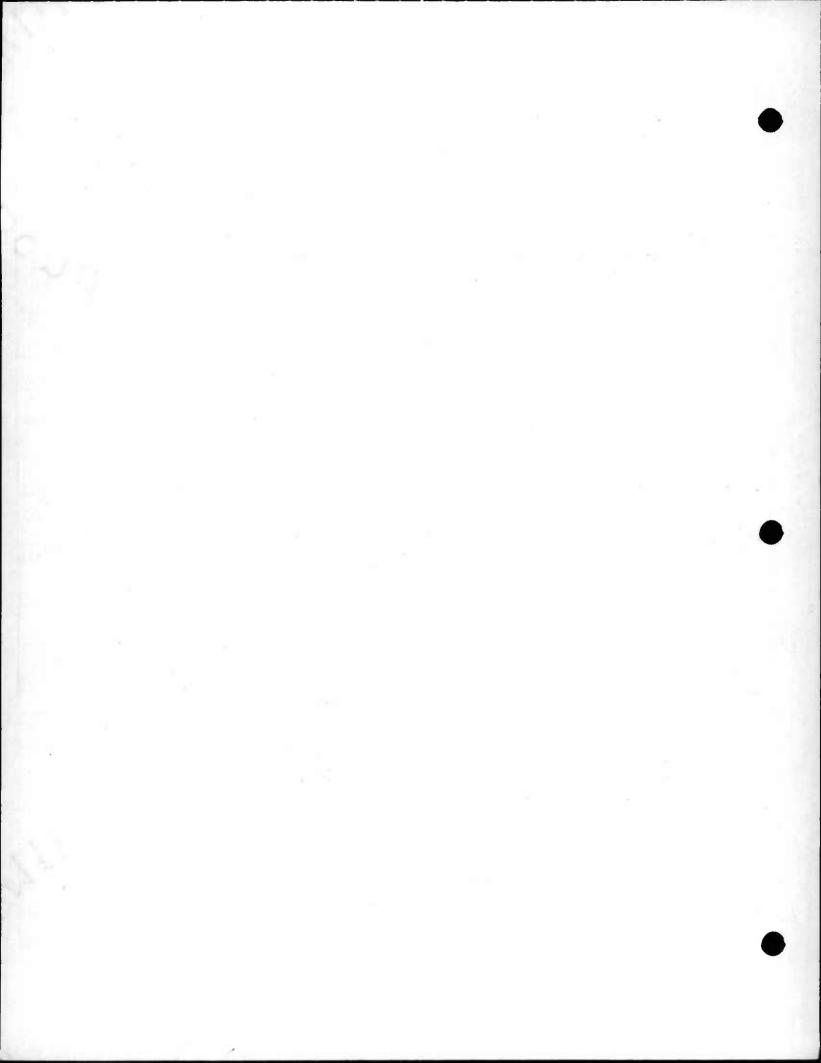
1 Y YES 2 NO Specify: WAS DECEDENT EYER IN U.S. ARMED FORCES? 15 YES 2 NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 14. RACE — American Indien, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried Specify: White BY 3 Widowed 4 Divorced 1958-1962 Peruvian 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY ive kind of work done . Do NOT use retired.) College (1-4 or 5+) +4 Defense Audit Mgmt/ Elementary/Secondary (0-12) Branch Chief Health and Human Svcs. once. 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) Benjamin Navarro ¥ Claudia Florentini Navarro BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2 Sheila Navarro 19121 Treadway Road, Brookeville, MD 20833 be 20s. METHOD OF DISPOSITION

1 Durisi A Commetten 3 Removal from State
4 Donation Other (Specify) 20b. PLACE ANO DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must Crematory 7/17/95 Brentwood, MD Lincoln examiner 22. NAME AND ADDRESS OF FACILITY
Hines-Rinaldi Funeral Home 21. SIGNATURE OF JUNERAL SERVICE LICENSEE 11800 New Hampshire Ave Silver Spring MD completely filled in by the ial, cremation, or removal. medicai 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heert failure. List only one cause on each line. Interval Between cremation, or **IMMEDIATE CAUSE (Finel** Onset and Death event, the disease or condition_ much resulting in death) OL executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) months and com IUEN other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) attending physician a If eny, leading to immediate cause. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 signed by the atter Health and Mental PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 TYES 2 NO 1 YES 2 NO been of h has be Dept. t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate h Hem **EXAMINER?** HOSPITAL: 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 10 the 27. MANNER OF DEATH 26s. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? this c 26d. DESCRIBE NOW INJURY OCCURED marked, Natural 1 YES 2 NO BY After 2 Accident Investigation DIRECTOR: A hours after de tem 28 is n 3 Suicide 28e. PLACE OF INJURY — At home, larm, atreet, lectory, office building, etc. (Specify) 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTE be filed within 72 hours at IMPORTANT; If Item 21 29s. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. TIT S'OF CERTIFIER 255. BIGNATE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 14,1995 35635 MIS 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) 18111 Prince Philip Drive, Olney, MD Dr. Joseph Kaplan; 31. OATE FILED (Month, Day, Year)

JUL 17 1995 22. REGISTRAR'S SIGNATURE who davelor Randall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within to their death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

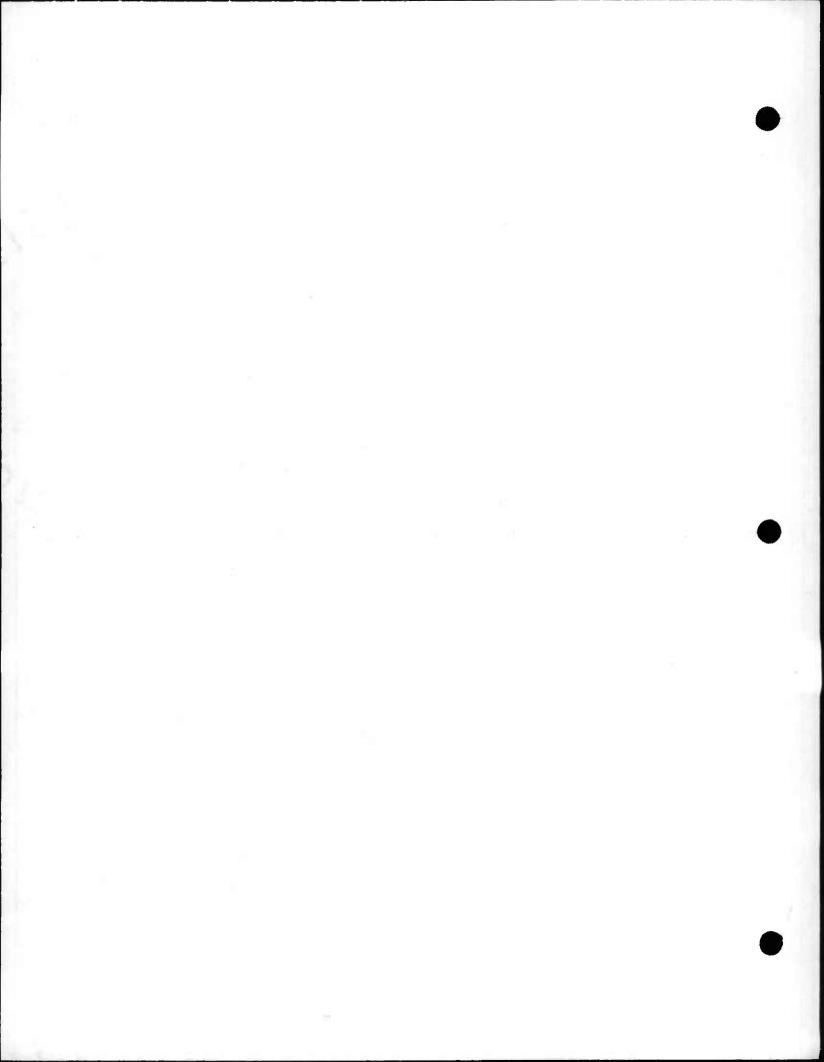
FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH													
	AHALY	A	NARAYA	NAN						JULY				
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. I	last birthday)		R 1 YEAR	-	24 HRS.	7. DATE OF		, -	8. BIRTH	IPLACE (State or Foreign
	NONE		1 🗆 M 2 😾 F	57	YRS.	MONTHS	DAYS	HOURS	MIN.	SEPT.		937	Counti	INDIA
	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CIT	Y, TOWN	OR LOCATI	ON OF DE		17"		INTY OF D	
DIRECTOR	WASHINGTON RESIDENCE OF DEC	ADVEN	TIST HOS	PITAL			TAKOMA PARK					MO	NTGC	MERY
<u> </u>	10a. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN	OR LOCA	TION						10d. INSIDE CITY
8	INDIA	NC	NE	MADRAS									LIMITS?	
A I	10e. STREET AND NUMBER							H. ZIP COD	E			10g. CIT	IZEN OF V	WHAT COUNTRY?
FUNERAL	M 7 E 3r	d AVE.	ASHOK	NAGAR				600	083				IND	
3	11. MARITAL STATUS			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO			WAS DE	CENOENT (OF HISPAN	IIC ORIGIN? (S	pecify Yea	or No-	14. BACE	- American Indian
BY	1 Never Married 2 3			MAR OR DATES	NO			2 V NO		n, Puerto Rice	n, atc.)		Speci	k, White, etc.
	- C-1-10				A									ASIAN
ETED	(Specify only	EDENT'S EDU- y highest grade	cation completed)		Give kind of	work done	during m	ON ost of working	ng	16b, KII	OF BUS	INESS/IN	DUSTRY	
2	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)	TRAVEL AGENT TRAVEL AC								Thias	
COMPL	17. FATHER'S NAME (First, M	iddle, Last)			TIMAT	וא אנ	ATTATA T	10 1407	UEDIO MAI	15 (5)			L AC	ENCY
	NAGARAJ		RAO					10. MUT		ME (First, Midd				
H	19a. INFORMANT'S NAME (7		1670	1	19b. MAILING	ADDRES	S (Street	and Number		Route Number,			n Codel	
임	USHA PAN	CHANAT	HAN							ADAVGI				70020, INDIA
- 1	20a. METHOD OF DISPOSITI			20b. PLACE	EANDDATE	OF DISPO	SITION /N	ame of	لد و د	DATE	_		City or To	
	4 ☐ Donetion 5 ☐ Other	n 3 ⊔ Remo (Specify)	oval trom State	cemetery, c	MRERS	ther place	МАТО	ORY	7	/18				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY													
	DI.M	Chi	anler	M	00091	. N	. W.	CHA	MBER	S CO.	INC.	SIL	VER	20910 SPRING, MD.
	23. PART I. Entar the di ahock, or he IMMEDIATE CAUSE (Fin disease or condition resulting in death)	eart lamure.	CHRON	IC MYEL	OGENO	US I								Approximate Interval Between Onset and Daath
MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):													
۳ ا	PART ii. Other algoritica	nt condition	a contributing to	death but not		la Ab								
MEDICAL	- agmio	- Constituti	e contributing to	death but not	reauting	iting in the underlying cause given in Pa					PERFORI	MED?	246.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
_	DID TOBACCO U	SE CONTR	RIBUTE TO CA	USE OF DEA	ATH YE	s 🗆	NO D	UNC	ERTAIN	101				1 PYES 2 NO
3	25. WAS CASE REFERRED TO EXAMINER?				CE OF DEAT									
š	1 YES 2 NO		HOSPITAL:	ER/Outpatient	3 DOA	OTHE		10 5 A	sidenca	6 Other (Sp	ecify)			
PHYSICIAN:		Pending	28e. DATE OF (Month, D	INJURY ay, Year)	28b. TIM INJ		28c. IN.	URY AT PRK? YES 2		28d. DESCRI		JURY OC	CURED	
ED BY	2 Accident 3 Suicide 8	F INJURY At h	ome, farm, s				NO	28t. LOCATIO	N (Street ar	nd Number	or Rural A	loute Number,		
		fetermined								, 0. 10				
COMPLET			CIAN: To the best of R: On the basis of e											and manner sa stated.
H	296. SIGNATORE AND THE	OF CERTIFIER	1					29c. LICE	NSE NUM	BER	Т	29d. DAT	E SIGNED	(Month, Day, Year)
2	Fluilly	5/	To mo	2				D2	1900				JULY	18, 1995
-	30. NAME AND ADDRESS OF SMITH S.			7610 C			T.	TANA	MA D	V ACL	D 0			
ŀ	31. DATE FILED (Month, Day.	Year)	37. REGISTIRA	R'S SIGNATIONE	A	T TVA	2009	THIO	WA F	CLUL . IV	W. 2	OATS		
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V	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIF	TMENT OF	HEALTH AND DEATH		GIENE G. NO.		
į.	1. DECEDENT'S NAME (First, Middle, La	Athol Hill No	ortham			2. DATE OF DE	ATH	3. TIME OF DEATH 5:15A.	
	4. SOCIAL SECURITY NUMBER 554-21-1044	1 □ M XX F	yrs. lest birthday) 90 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIR (Month, Day, Oct. 1:	Year)	BIRTHPLACE (State or Foreign Country) Indiana	
TOR	Greenbelt Nurs					HTAB	rof DEATH nce George's		
DIRECTOR	10a. STATE 10b. COU	ince George's						10d. INSIDE CITY LIMITS? XX YES 2 NO	
FUNERAL	7816–103 Hanove	er Parkway	Parkway		101. ZIP CODE 20770-2612			10g. CITIZEN OF WHAT COUNTRY? United States	
B	11. MARITAL STATUS 1 Never Married 2 Merried 3 X Widowed 4 Divorced	12. WAS DECEDENT EVER IN I FORCES? 1 YES IF YES, GIVE WAR OR DAT	X YNO	If yes, s	CENDENT OF HISPA pecify Cuben, Mexic S 2XXXNO Spec	an, Puerto Rican, e		4. RACE — American Indian, Black, White, etc. Specify: White	
COMPLETED	15. DECEDENT'S E (Specify only highest gn Elementary/Secondary (0-12) 12	DUCATION ide completed) College (1-4 or 5+) 2	completed) (Give kind of work done life. Do NOT use retired.)		ION nost of working		of Business/Indus	ЗТЯУ	
m l		Hi11					, Middle, Maiden Surname)		
TO BI	190. INFORMANT'S NAME (Type/Print) Thomas E. North		196. MAILING SAIT	ADDRESS (Street Le as #1	and Number or Rural	Route Number, City	or Town, State, Zip Co	pde)	
ISNE	20a. METHOD OF DISPOSITION 1 Grant 2 Assemble 3 Grant 4 Donation 5 Grant (Specify)	Met	PLACE AND DATE OF STA	Cremator	y July 19	,1995		a, Virginia	
ехашіпег	21. SIGNATIVE OF FUNERAL SERVICE	. Bogward	H.	4400	Powder M	ill Rd.	Beltsvi1	Home, P.A. Lie, Md. 20705	
event, the medical	23. PART I. Enter the diseases, o shock, or heert failur IMMEDIATE CAUSE (Finel disease or condition resulting in death)	e. List only one ceuse on eec	ch ilne.					Approximate interval Between Onset and Death	
RTIFICATION	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that inflieted events resulting in death) LAST Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
CAL	PART II. Other eignificent condition	II. Other eignificent conditione contributing to deeth but not resulting in the underlying cause given in Part I. 24a, WAS PER 1 YES							
S N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO LOUNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)							1 - YES 2 NO	
YSICI/	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outpat	lent 3 🗆 DOA	OTHER: 4 Nursing Hor	ne 5 🗆 Rasidence	6 Other (Specif	(y)		
TED BY PH	27. MANNER OF DEATH 1 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	JRY W	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW INJURY OCCURED			
	3 Suicide 8 Could not b	PLACE OF INJURY — building, atc. (Specify	- At home, farm, s	treet, factory, offic	et, factory, office 28f. LOCATION City or Town			Street and Number or Rural Route Number, State)	
B	29a. CERTIFIER (Check only one) 1 CERTIFYING PHY 2 MEDICAL EXAMI	SICIAN: To the best of my knowled NER: On the basis of examination a	ige, daeth occurre and/or investigation	d at the time, date n, in my opinion,	a and place, end du death occured at the	to the cause(e) er	nd manner as stated.	:suse(e) end menner ee stated.	
TO BE COMPI	29b, SIGNATURE AND TITLE OF CERTIF	Buard	Buard			MBER 287	>7/	SIGNED (Month, Day, Year)	
	30. NAME AND ADDRESS OF PERSON V M BERAR D 31. DATE FILED (Month, De Veril 200	7305 BAL	H (ITEM 27) (Type,	Print) Av	E 107	C	Ilege Pr	AKK, MeD 2074	
	31. DATE FILED (Month, DZ Tr) 199	5 Juntanian	V Droath						



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DIVISION OF VITAL RECORDS, P.O. BOX 68760

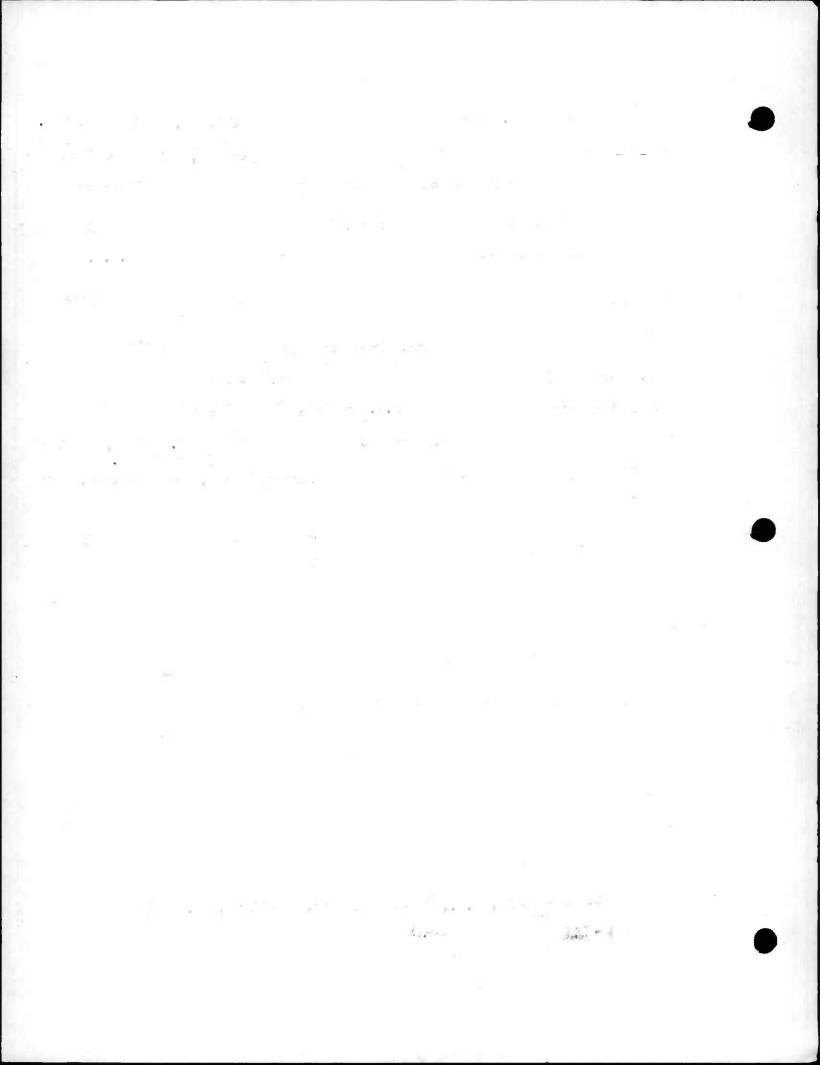
page 5 should director, I funeral (the attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or removal. 0 HOSPITAL DR ATTENDING PHYSICIAN: The law requires that signed Health a been s has be Dept. this certificate has with the State Darked, or Item DIRECTOR: After the hours after death w TO THE HOSPITAL DR ATT TO THE FUNERAL DIRECTS be filed within 72 hours at IMPORTANT: If Item 2

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. OECEOENT'S NAME (First, Middle Last) 2. DATE OF DEATH 3. TIME OF DEATN YEAR Beatrice L. Neder 11:10 A.MM July 20. 1995 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 F DAYS HOURS MIN. 218-70-1683 June 7. Maryland 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION DE DEATN 9c. COUNTY OF OEATH Frostburg Village Nursing Home DIRECTOR Frostburg Allegany RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Allegany Ellerslie 1 XYES 2 ND 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN DF WHAT COUNTRY? 10216 Mason Dixon View U.S.A. 21529 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ND ND IF YES, GIVE WAR DR OATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuban, Mexicen, Puerto Ricen, atc.)

1 YES 2 ND Specify: 14. RACE - American Indian, Black, While, etc. 1 Never Merried 2 Married В 3 Widowed 4 Divorced White COMPLETED 16a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEOENT'S EDUCATION 18b. KINO DF BUSINESS/INQUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 8 Pajama Factory Steam Press Operator 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) Clayton Rankin BE Pearl Chanev 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Marguerite Logue P.O. Box 203, Ellerslie, Maryland 21529 20a METNOD OF DISPOSITION
1 Dariel 2 Cremetion 3 Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE St. George Cemetery 7/22 4 Donation 5 Other (Specify) Mt. Savage, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE. 22. NAME ANO ADDRESS OF FACILITY 57 Frost Ave. ohn Durst Funeral Home, Frostburg, Md. 21532 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Finel** Onset and Death disease or condition Mela Static resulting in deeth) DUE TO (OR AS A CONSEDUENCE OF): Poi laliva Cars CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEDUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated evente resulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? trama 1 TYES 2 KND PSY Chry milos 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES PHYSICIAN: NO V 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE DF DEATH (Check only one) OTHER: 1 TYES 2 DATE ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 27. MANNER OF GEATN 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. OESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES B 2 NO 2 Accident 28e. PLACE DF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Nomicide 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the ceuse(a) and menner ee stated. (Check only one) 2 MEDICAL EXAMINER: On the beels of examination end/or inve 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 44 2 30. NAME AND ADDRESS OF PERSON WND COMPLETED CADSE OF OEATN (ITEM 27) (Type, Print) S. L. Sandhir. 48 Tarn Terrace, Frostburg, Md. 21532

32. REGISTRAR'S SIGNATURE

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ID THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 724 hours after death, Page 6 may be retain	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 sho		MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notifi
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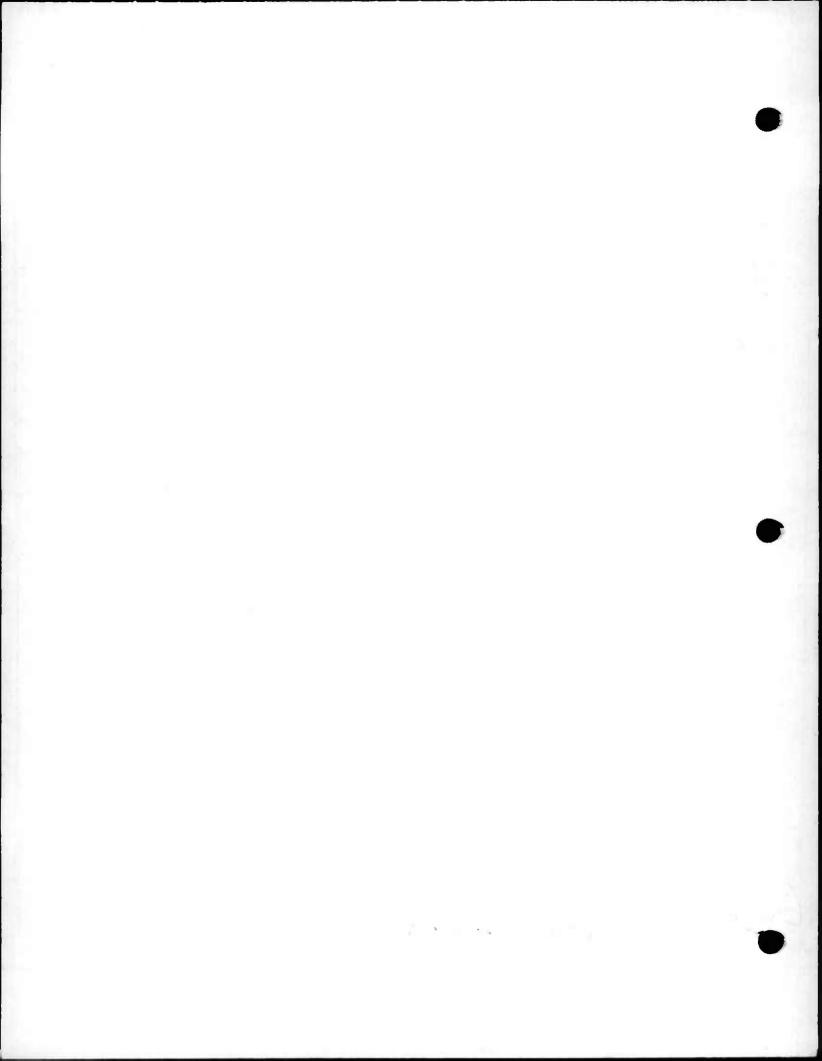
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle Last 2. DATE OF DEATH 3. TIME OF DEATH USON DAY 1995 1:51 ano м 1011 16 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday, IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State of Foreign 122-34-1903 51 1 M 2 X F dctober .1943 N. 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Holy Cross Hospital Silver Spring Montgomery RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Clinton Maryland Prince George's 1 X YES 2 NO FUNERAL 10a STREET AND MIMBES 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3406 Delancey Street 20734 USA 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married В 1 YES 2 NO Specify: Specify: African 3 Widowed 4 Divorced merican COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Glam kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complet 18b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 pr 5 +) 4 Social Worker Montgomery Co. Gov't 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Arthur Jefford Stephenson BE Anna Beatrice Colonel 19a. INFORMANT'S NAME (Type/Print)
Andrew "Andy" Stephenson 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20784 9 7603 Fountainebleau Dr. Unit 2326, New Carrollton, Nd METHOD OF DISPOSITION 206. PLACE AND DATE OF DISPOSITION (Name of /23/9 20c. LOCATION — City or Town, Stata 110 Burial 2 Cremation 3 Removal from State cemetery, cremetory or other plece)
<u>George Washington Cemetery</u> Donation 5 - Other (Specify) Adelphi, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Plearles 10 Francis Gasch's Sons Funeral Home, 4739 Baltimore Avenue, Hyattsville, Md. 20781 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) pais DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF). If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO 15 UNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26, PEACE OF OEATH (Check only one) FYAMINER? HOSPITAL OTHER: 1 YES 2 70 1 Inpatient 2 PR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNEB OF OEATH 28a. OATE OF INJURY (Month, Day, Year) 28c, INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending В 1 YES 2 NO Investigation 2 Accident 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. PLACE OF INJURY — At home, term, street, fectory, office building, etc. (Specify) COMPLETED a Could not be 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) end manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE myrou enken m d. 0 66 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHOREFIEL



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32 REGISTRAR'S SIGNATURE



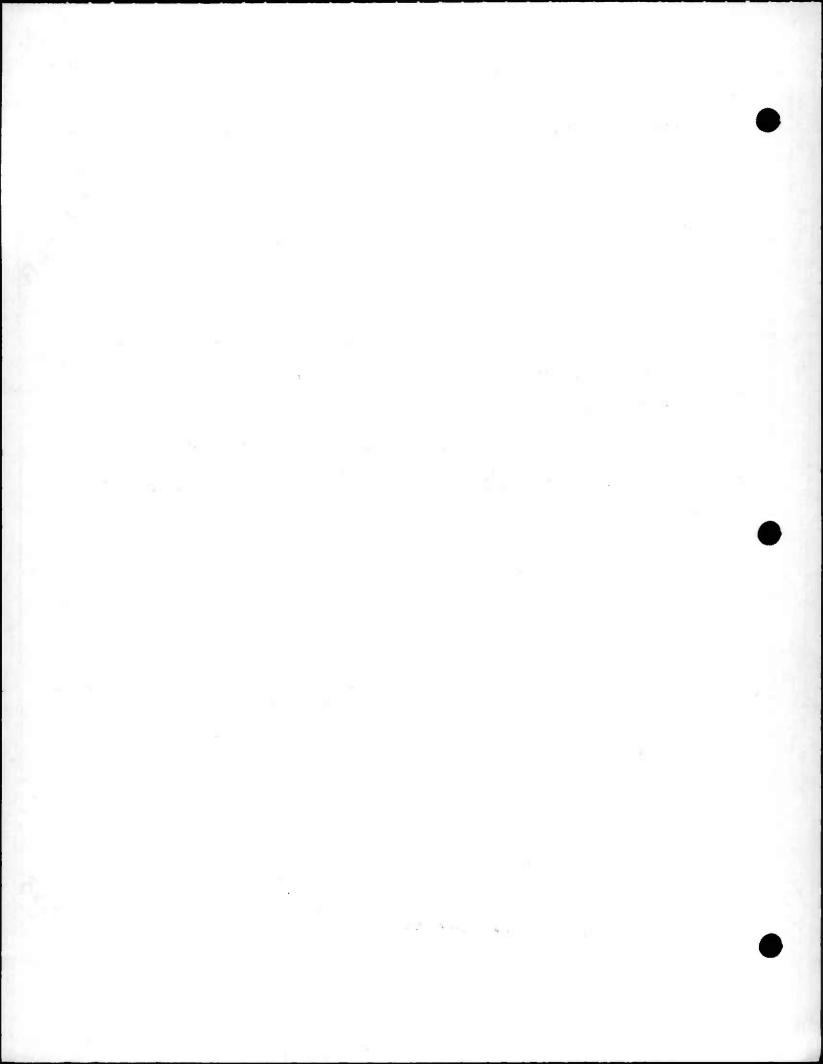
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	and the continue of the dead beat beat by the section of the
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATN Samuel P. Nalley Sr. July 18, 1995 6:55 рм 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 5. SEX B. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTNPLACE (State or Foreign 1 M 2 - F 578-24-3967 April 14 1924 Maryland In by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should removal. 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR 6107 Seabrook Road Seabrook Prince George's 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Prince George's Seabrook 1 X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6107 Seabrook Road 20706 U.S.A. after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 △ YES 2 □ NO IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Ricen, atc.) 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried BY 1 YES 2 NO Specify: Specify: 3 Widowed 4 Divorced 1943-1945 White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Systems Analyst U.S. Government 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Albert Sydney Nalley Sr. Mary Ada Wildman notified at BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street end Number or Rural Route Number, City or Town, Stale, Zip Code) 2 Ann W. Nalley 6107 Seabrook Road Seabrook, Maryland 20706 be 20s. METHOD OF DISPOSITION
1 Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — Cify or Town, State must Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 7/21/95 Silver Spring, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Francis Gasch's Sons Funeral Home - 4739 Pleades Baltimore Avenue, Hyattsville, Md. 20781 medical filled in by t 23. PART i. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or haart fallure. List only one cause on each line ò intarvai Between Onset and Daath IMMEDIATE CAUSE (Final mpletely filled cremation. the disease or condition resulting in death) neumonia. event, OUE TO (OR AS A CONSEQUENCE OF): in and com to burial, (mpoired (o 01 9 traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate physician ne prior to ementia. CSUSO, Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF) the attending p that initisted events resulting in dasth) LAST Injury, or PART II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24a, WAS AN AUTOPSY by and Hyperparathyroidism, Recurrent UTI PERFORMED? апу signed Health a 1 YES 2 NO U-inary Stones, Gouty Arthritis. 1 YES 2 THO t, of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate h HOSPITAL: OTHER: 1 YES 2 10 1 Inpatient 2 ER/Ouipatient 3 DOA 4 ☐ Nursing Name 5 ☐ Residence 8 ☐ Other (Specify) 10 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked. with (1 Netural 1 YES 2 NO BY After death 2 Accident 28e. PLACE OF INJURY — Al home, ferm, street, factory, office building, atc. (Specify) 3 Suicide ETED 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) .69 6 Could not be DIRECTOR: hours after 4 🔲 Homicide 28 determined hours 29e. CERTIFIER

(Chack only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner se stated. COMPL THE HOSPITAL OF THE FUNERAL CO BE filed within 72 h 2 MEDICAL EXAMINER: On the besie of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF GENTH 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) D 31001 D 7/20/95 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF ORATH (ITEM 27) (Type, Print) 75005, een way Contr. Dr. #430 Stuart J. Toffer; 72, M.D. Green belt, Md. 20770.

A REGISTRAR'S SIGNAT



YEAD

9c. COUNTY OF DEATH

Prince George's

10g, CITIZEN OF WHAT COUNTRY?

U.S.A.

REG. NO.

DAY

1995

2. DATE OF DEATH

July 13,

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

William

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7. DATE OF BIRTH (Month, Day, Year) IF UNDER 24 HRS. 578-36-8462 1 X M 2 - F 87 Dec. 9, 1907 detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 3023 Tucker Road Fort Washington RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Prince George's Fort Washington FUNERAL 10e STREET AND NUMBER 101, ZIP CODE 3023 Tucker Road 20744 hours after death. Page 6 may be retained by the hospital or attending physician. 11 MADITAL STATUS 12. WAS DECEDENT, EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 X Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced 1925 - 1928 COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY entary/Secondary (0-12) College (1-4 or 5 +) Lens Grinder Federal Government once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) page 5 should be notified at Joseph S. Neal BE Alice Meeks 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Doarthy G. 3023 Tucker Road, Ft. Washington, Md. 20744 Neal pe 20e. METHOD OF DISPOSITION
1\(\subseteq \text{Murlet 2} \subseteq \text{Cremetion 3} \subseteq \text{Ret}
4 \subseteq \text{Donation} 5 \subseteq \text{Other (Specify)} \] 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must funeral director, Maryland Veterans Cemetery 7/17/95 Cheltenham, Md. examiner OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home filled in by the fu-6160 Oxon Hill Rd. Oxon Hill. Md. 20745 medical 23 PART | Enter the seases, or complications that coused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, ahock, di heart fallure. Liet only one cause on each line cremation, or IMMEDIATE CAUSE (Final the disease or condition resulting in death) been signed by the attending physician and completely it. of Health and Mental Hygiene prior to burial, crematic rostato Cancer, event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediata 8 cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 Injury, PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? that shows any 1 TYES 2 TX NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: Dept. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item DIRECTOR: After this certificate hours after death with the State HOSPITAL: OTHER: 1 YES 2 XNO OTHER:
4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked, 1 X Natural 5 Pending M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 00 COMPLETED 6 Could not be 4 Homicide 28 determined Item 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL DE FILED WITHIN 72 he IMPORTANT: If Its THE HOSPITAL (THE FUNERAL D filed within 72 h 2 MEDICAL EXAMINER: On the beals of exemination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIF 29c. LICENSE NUMBER BE 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Yeung mb 8926 Wood Yava Ka1-414 31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S SIGNATURE

Reid

6. AGE (In yrs. last birthday)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

Nea1

11:05

6. BIRTHPLACE (State or Foreign

North Carolina

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

Specify: White

1 YES 2 NO

Approximata

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 YES 2 NO

interval Between

Onset and Death

3 44

3. TIME OF DEATH

A.

29d. DATE SIGNED (Month, Day, Year) DHMH-16 Ray 1/89

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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The Jaw requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should by	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified a
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31. DATE FILED (Month, Day, Year)

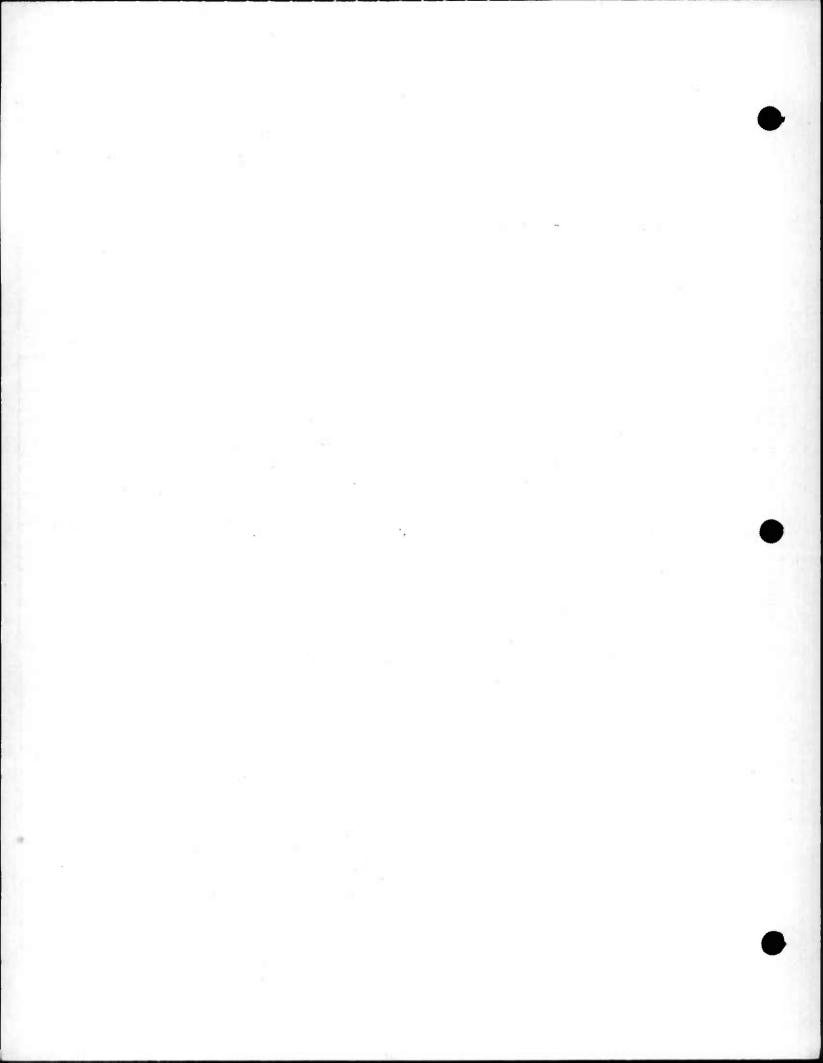
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		1 - FOR STATE REGISTRAR		STATE OF I	MARYLAND /	DEPAR					MENTAL	HYGIEN			
		1. DECEDENT'S NAME (First	t, Middle, Last)									OF DEATH		3	. TIME OF DEATH
	- 1	ROBERT	ROBERT PAUL O'								JULY 18, 1995			YEAR	3:06 A M
		4. SOCIAL SECURITY NUM		5. SEX	. SEX 8. AGE (In yrs. last birthday)			IF UNDER 1 YEAR IF UNDER 24 HRS.			7. DATE OF BIRTH			BIRTHPL	ACE (State or Foreign
	-	206-38-7614		1 M 2 F	46	YRS.	MONTHS	DAYS	HOURS	MIN.		30,194	/LQ	Germ	01337
		9a. FACILITY NAME (If not in		treet and number)			9b. CITY	, TOWN O	R LOCATI	ON OF DE		30,190	9c. COUNT		
1 8		Washington	Advent	ist Hosp	ital		Та	koma	Par	·k			Mont	come	rv
غ ا		RESIDENCE OF DE	10b, COUNT										Hone		
DIRECTOR			1252 1000				Y, TOWN								Dd. INSIDE CITY
		Maryland		gomery		1	lockv								YES 2 NO
FUNERAL		4605 West F		D				101.	. ZIP COO						AT COUNTRY?
		11. MARITAL STATUS	rankio		T EVER IN U.S. AF	W4F-0	1.0			853				.S.A	
II.		1 Never Married 2	Married	FORCES? 1	YES 2 VI			If yes, spe	ecify Cuba	n, Mexica	n, Puerto F	? (Specify Yea lican, etc.)	or No — 1	4. RACE — Black, V	- American Indian, Vhita, atc.
À		3 Widowed 4 Divo	orced	IF YES, GIVE V	AR OR DATES			1 YES	2 🔀 NO	Specify	y:			Specify: Whi	t o
<u> </u>		15. DEC	EDENT'S EDU	CATION	18a. DE	CEDENT'S	USUAL O	CCUPATIO	ON .		16b.	KIND OF BUS	BINESS/INOU		LE
14		Elementary/Secondary (6		College (1-4 or 5	life.	ive kind of Do NOT u	work done se retired.)	during mos	st of workin	ng					
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COMPLETED		17. FATHER'S NAME (First, M	fiddle, Last)						18. MOTI	HER'S NA	ME (First, N	fiddle, Maiden	Sumame)		
BE		Thomas H.	O'Brie	n					Pau	lett	e Ma	bereau	1		
		19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	(Street ar	nd Number	or Rural I	Route Numb	er, City or Tow	n, State, Zip C	ode)	
- 1 -		Thomas H.		n	46	605 W	lest	Fran	kfor	t Dr	ive	Rocky	ville,	Mary	1and20853
20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE DATE) 20c. LOCATION						CATION — CI	City or Town, State								
		4 Donation 5 Other		1	Metro	olit	an C	rema	tory	7	7/19/	9 5 Ale2	kandri	a,Vi	rginia
	ı	21. SIGNATURE OF FUNERA	L SERVICE UK	ENSEE LA	1.1				D ADDRES			Funer	ral Ho	m o	Tno
		Mach	4.	Ville	elle										MD 20901
	٦	23. PART I. Enter the d	iseesea, Dr d	omplications the	t caused the de	eth. Do i	not enter	the mod	de of dyl	ng, aucl	h aa card	lac or respi	retory arrec	rt,	Approximata
		enock, or n IMMEDIATE CAUSE (Fir	eert tallure.	List only one cau	se Dn eech line).						•			Interval Between Onset and Death
	disease or condition ACOUTRED TAMBLE DEFICIENCY SYNDROME						UNKNOWN								
	DUE TO (OR AS A CONSEQUENCE OF):														
Z				b											
CERTIFICATION		Sequentially list condit if any, leading to imme	diate	DUE TO	(OR AS A CONSE	DUENCE O	F):		-						
2		CAUSE (Disease or Inju		2											
		that initiated events resulting in death) LAS	, I	DUE TO	(OR AS A CONSEC	DUENCE O	F):								
	Ì	Total III good III go		ś											
i ~	- 11	PART II. Other significe	nt condition	a contributing to	deeth but not r	esulting	in the un	derlying	cause g	lven in	Part I.	24a. WAS AN	AUTOPSY	24b. W	ERE AUTOPSY FINDINGS
MEDICAL		DEMENTIA	DUE TO	O HIV, WA	ASTING S	YNDR	OME,	ANE	AIM			PERFOR		AV	MILABLE PRIOR TO OMPLETION OF CAUSE
		LEUKOPEN	IA. AS	PIRATION	PNEUMON	IA					-	1 TES 2	Ø MO		F DEATH?
		DID TOBACCO U					S 🖾 I	ио П	LINC	ERTAIN				'	YES 2 NO
PHYSICIAN:		25. WAS CASE REFERRED TO				E OF DEAT			0110	CKIAII	-				
Sic		EXAMINER?		HOSPITAL:	ER/Outpatient 3	XI DOA	OTHER 4 Num		5 Pa	aldence	5 ☐ Other	(Panaika)			
<u>`</u>		27. MANNER OF DEATH		28a. DATE OF		28b. TIM	E OF	28c. INJU	JRY AT			CRIBE HOW II	NJURY OCCU	RED	
8	ì		Pending Investigation	(Month, Di	ny, rear)	INJ	URY	1 Y	ES 2	NO					
ED B	Ì	3 Suicide 8	Could not be	28s. PLACE O	F INJURY — At ho atc. (Specify)	me, farm,	streat, fact	ory, office				TION (Street a	and Number or	Rural Rout	e Number,
1 2	1	4 Homicide	determined	- Januaria,	and (opodiny)						City o	r Town, State)			
COMPLET		29a. CERTIFIER 1 (Checklonly 1	IFYING PHYSIC	CIAN: To the best of	my knowledge, de	ath occurre	ed at the ti	me, data a	and place.	and due	to the caus	e(s) and man	ner as stated		
MO	H	one) 2 MEDI	CAL ENAMINE	t. On the bests of e	Ination and/or I	investigatio	n, in my o	pinlon, de	oth occur	ed at the	time, deta	and place, an	d due to the	cause(s) ar	nd manner as stated.
- 1	Ì	296. SIGNATURE AND TITLE		11. 1	11	-	1	1	29c. LICE	NSE NUM	IBER				onth, Day, Year)
BE.		MM	-11	(1) 1	YXX	11/	VC	VV	DO	0149	9				1995
티오	-	30. NAME AND ADDRESS OF	DEDCON WIN	COMBI EXED ONLE			-								

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

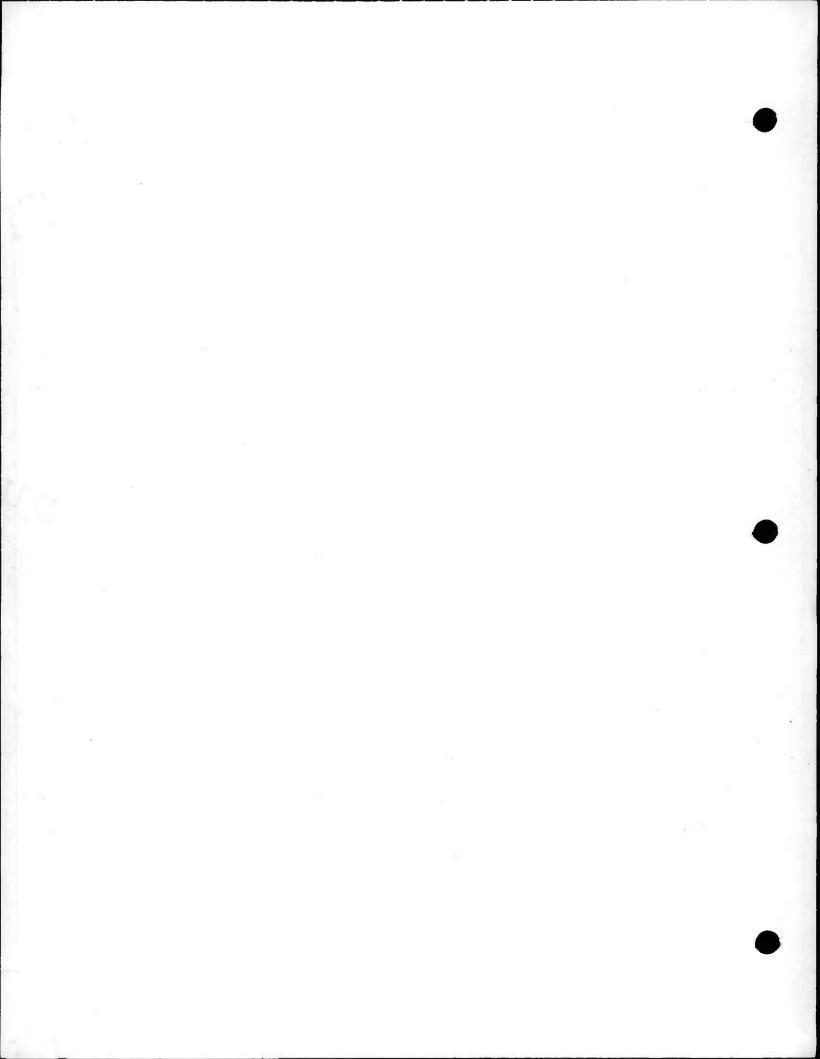
DR. LEWIS HILLIARD DENNIS 6201 GREENBELT RD. #U-1 COLLEGE PARK, MD

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH STNESF July 13,1995 5:45 P M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birtnday) 5. SEX 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 577-28-7856 71 YRS. September 6,1923 Massachusett permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Stella Maris Nursing Home Towson Baltimore RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Silver Spring Montgomery 1 YES 2 | NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 12500 20904 Davan Drive United States retained by the hospital or attending physician. 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 \boxtimes YES 2 \square NO IF YES, GIVE WAR OR DATES WW II 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 XNO Specify: White ΒY Specify: 3 Widowed 4 Divorced ETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 Civil Engineer-NASA Federal Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ernest Stephen Ott notified at Mary Dondero BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Marie Ott Davan DriveSilver Spring, Maryland 20904 Mrs. Jean 12500 hours after death. Page 6 may be pe 20a METHOD OF DISPOSITION
1 \(\text{D} \) Buriel 2 \(\text{D} \) Cremation 3 \(\text{D} \) Removal from State 20b. PLACE AND DATE OF OISPOSITION (Name of 20c. LOCATION — City or Town, State must DATE Gate of Heaven Cemetery 7-17-9\$ Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 NewHampshireAveSilverSpring, M.D. and completely filled in by the butial, cremation, or removal. medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, Approximate shock, or heart fallure. List only one cause of Interval Between **IMMEDIATE CAUSE (Final** Onset and Death the 4511disease or condition_ resulting in death) traumatic event, DUE TO JOR AS A CONSEQUEN executed CERTIFICATION Sequentistly list conditions, Hygiene prior to this certificate has been signed by the attending physician is with the State Dept. of Health and Mental Hygiene prior to riked, or item 23 shows any injury, or other traum if sny, leading to immediate cause. Enter UNDERLYING requires that the death certificate be CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 246. WERE ALITOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE 1 T YES 2 T NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO I UNCERTAIN I PHYSICIAN: WE 26. WAS CASE REFERRED TO MEDICAL 26. PLACE OF BEATH (Check only or The HOSPITAL: I THE PENO I ☐ Inpetient 2 ☐ ER/Outpat O DOA raing Home S - Residence S - Other (Specify) 27. MANNER OF DEATH 25s. DATE OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Distatural 1 YES 2 NO BY After 1 OR ATTENDING 2 Accident 3 Suicide 26e. PLACE OF INJURY -281. LOCATION (Street and Number or Rural Route Number, City or Search State) 99 8 Could not be DIRECTOR: / COMPLETED 4 - Homicide 28 Пещ 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my know See, death occurred at the time, date and place, and due to the vause(s) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL DE filed within 72 he IMPORTANT: If its 2 MEDICAL EXAMINER: On the basis of examination and/or investigation; investigation; investigation; death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. LACENSE NUMBER 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Moven, Day, Mur) BE 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) Edward Nakhuda, MD Dulaney Valley Road Towson, Maryland 21204 32. REGISTRAR'S SIGNATURE 31. OATE FILED (Month, Day, Year) 1995



2, 3 should

	Page		
HYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page	the State Depti, of Mealth and Mental Hygiene prior to burial, cremation, or removal.	INDUCTANT If them 20 is morehard as them 20 shows our letters as ather tensionals arreading account to mostly as a mostly of the mostly of the same of
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32. REGISTRAR'S SIGNATURE Julia Davelson Revolate

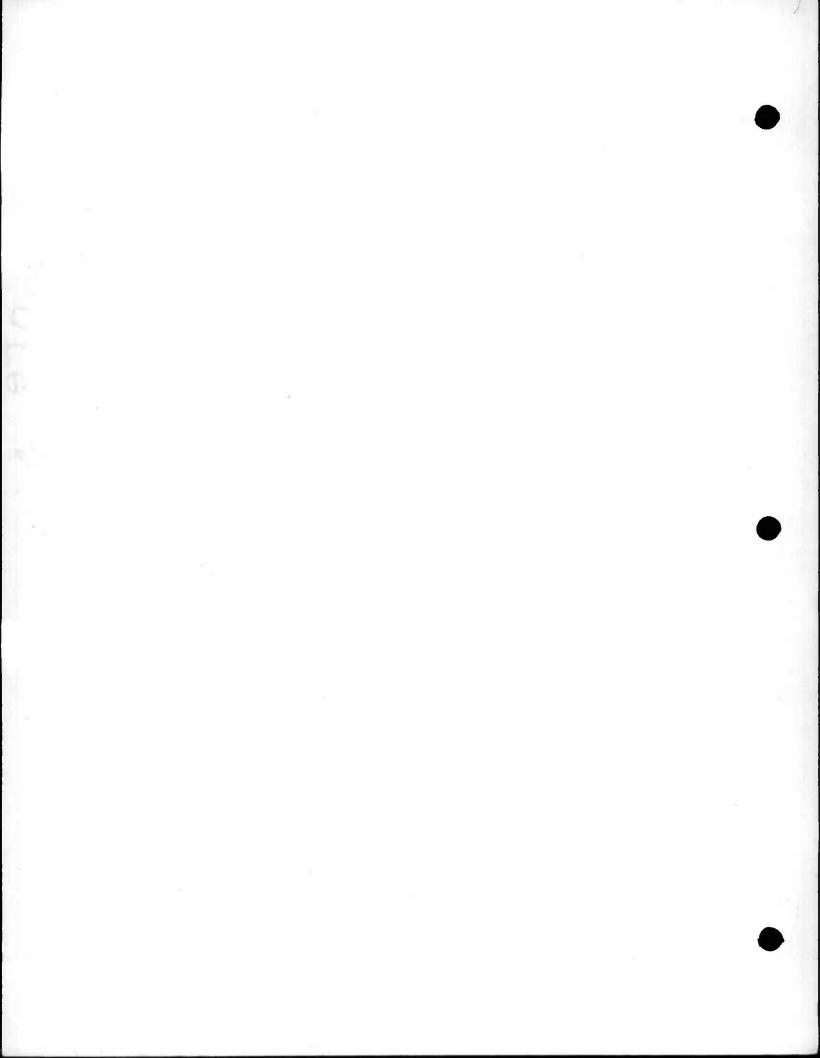
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95 23414 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF CEATH O'Neill Marie Griffith July 19. 1995 3:06 A SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year)
Jan. 2, 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 578-36-3514 1 M 2 V Washington, 9e. FACILITY NAME (if not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 9510 Beck Court Bethesda Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Bethesda 1 YES 2 NO FUNERAL 10e, STREET AND NUMBER 101, ZIP COOF 10g, CITIZEN OF WHAT COUNTRY? 9510 Back Court United States 20817 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or Noif yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried ВY 1 TES 2 X NO Specify: Specify: 3 Widowed 4 Divorced white COMPLETED 15. DECEOENT'S EOUCATION 16a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY (Specify only highes Elementery/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Griffith Thomas Vincent BE Margaret Rout 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 O'Neill Same as 10 Eugene 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE Chesapeake Crematory

Chesapeake Crematory 7-19 Beltsville, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. Illem 933 Gist Avenue, Silver Spring, MD 20910 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximete shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death Thelionie disease or condition 2/1 resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING OUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 1 - YES 2 1 NO OF DEATH? 1 - YES 2 1 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\text{NO \(\text{X} \) UNCERTAIN \(\text{\(\ext{\) \}}}}\end{\(\text{\(\text{\(\text{\(\text{\(\text{\(\text{\(\ext{\(\text{\(\text{\(\text{\(\ext{\(\text{\(\text{\(\ext{\(\ext{\) \}}}}\end{\(\text{\(\ext{\(\text{\) \}}}\end{\(\text{\(\ext{\) \}}}\end{\(\text{\(\text{\) \ext{\(\text{\(\text{\(\text{\(\text{\) \}}}\end{\(\text{\) \} \end{\(\text{\(\ext{\) \ext{\(\ext{\) \}}}}\end{\(\text{\(\ext{\) \}}}\end{\(\text{\(\ext{\) \ext{\} \ext{\} \ext{\) \ext{\(\ext{\} \ext{\) \ext{\(\ext{\) \ext{\(\ext{\) \} \ext{\(\ext{\(\ext{\) \ext{\(\ext{\) \ext{\(\ext{\| \exitinity} \ext{\(\ext{\| \ext{\} \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \ext{\| \exi}} \ext{\| \ext{\| \exi{\| \ext{\| \ext{\| \exi{\| \ext{\| \exi}} \ext{\| \exi{\| \exi}\| \exi{\| \exi}\| \ext{\| \exi{\| \exi}} \ext{\| \ex PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending Investigation м 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER 1XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as attated. 2 MEDICAL EXAMINER: On the beels of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 0205/6 ▶ July 19, 1995 2 E ANO ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

9410 Old Georgetown Road,

Bethesda, MD 20814-1700



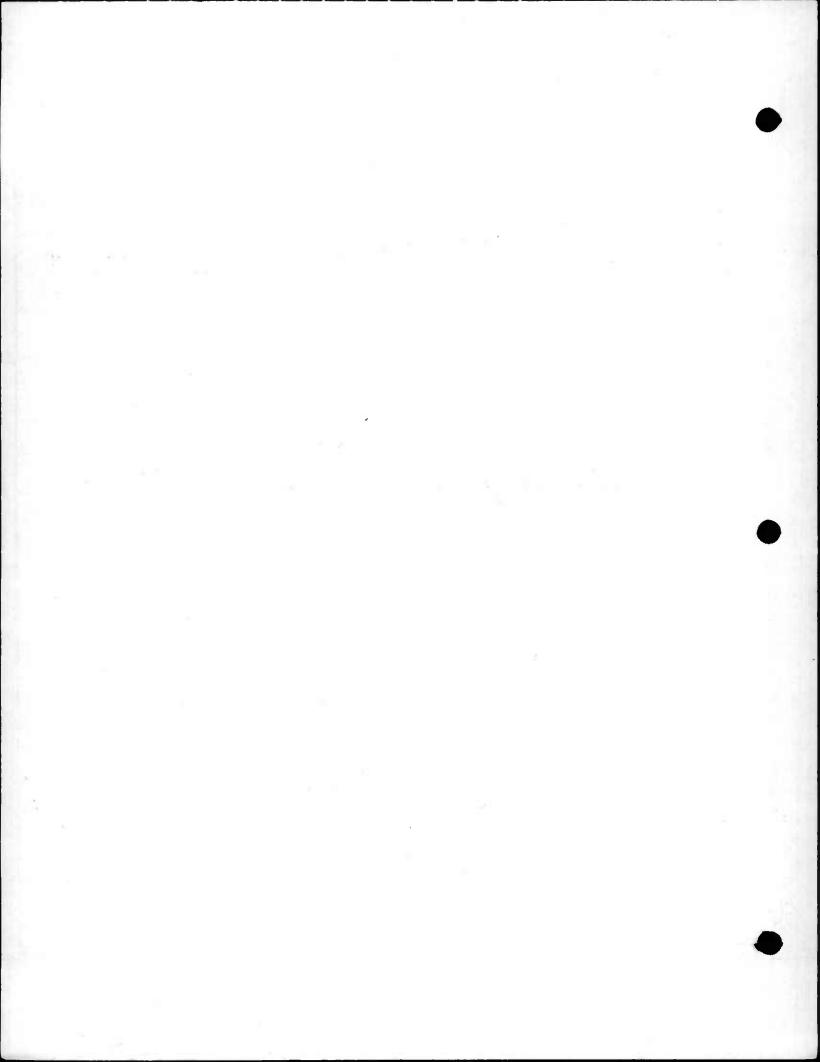
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JÜLŸ 17, VTVTAN OSTAS 1995 9:00 A. М 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH
JAN 12, IF UNDER 1 YEAR 6. BIRTHPLACE (State or Foreign 215-34-3372 1 - M 2 - F DAYS HOURS 84 NEW YORK be detached for use as the buriat-transit permit, Pages 1, 2, 3 should RELEASED BY DR. JOHN TAUBER, at once, DEPUTY MEDICAL, EXAMINER. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 8202 THOREAU DRIVE **BETHESDA** MONTGOMERY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY BETHESDA 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8202 THOREAU DRIVE 20817 UNITED STATES hours after death. Page 6 may be retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 24 NO WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif yes, specify Cuben, Maxican, Puerto Rican, etc.)
 U YES 24 NO Specify: 14. RACE — American Indian, Black, Whita, atc. 1 Never Married 2 1 Married В IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) SCHOOL TEACHER PUBLIC SCHOOL SYSTEM 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) MORRIS WENDER GUSSIE LEVINE BE funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MAX S. OSIAS 8202 THOREAU DRIVE - BETHESDA, MD. 20817 Pe 20a METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must 3 [] KING DAVID MEMORIAL GARDEN 7/19 4 Donation 5 Donat FALLS CHURCH, VIRGINIA medical examiner 21. SIGNATURE OF FURE 22. NAME AND ADDRESS OF FACHITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. filled in by the fution, or removal. 1170 ROCKVILLE PIKE, ROCKVILLE, MD or complications that caused the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, to. List only one ceuse on each line. r the diseases. ock, or heart 0 Interval Between IMMEDIATE CAUSE (Finel **Onset and Deeth** cremation. other traumatic event, the disease or condition AORTIC STENOSIS completely resulting in death) DUE TO (OR AS A CONSEQUENCE OF): and com ADVANCED HEART FAILURE 5 YEARS CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING law requires that the death certificate be CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST signed by the atter Health and Mental PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO CDMPLETION OF CAUSE OF DEATH? PERFORMED? 23 shows any 1 - YES 2 7 NO 1 - YES 2 - NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO DE UNCERTAIN I PHYSICIAN: Dept. certificate has b 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL OR ATTENDING PHYSICIAN: The HOSPITAL: 1 X YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 X Residence 8 Other (Specify) 27. MANNER OF DEATH 28b. TIME OF 28a DATE OF INJURY 28c. INJURY AT WORK? this c 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural
2 Accident TO THE HOSPITAL OR ATTENDING PH TO THE FUNERAL DIRECTOR: After the De filed within 72 hours after death w IMPORTANT: It Item 28 is mark 1 YES 2 NO BY Investigation 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER (Check only one) 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 286. SIGNATU RE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) ou do D23783 JULY 17, 1995 9 WHO COMPLETED CAUSE OF DEATH (ITEM 27) /54 DANIEL ESPOSITO, M.D., 5530 WISCONSIN AVENUE, CHEVY CHASE, MD 20815

32 MEGISTRAR'S SIGNATURE Files Davidoll

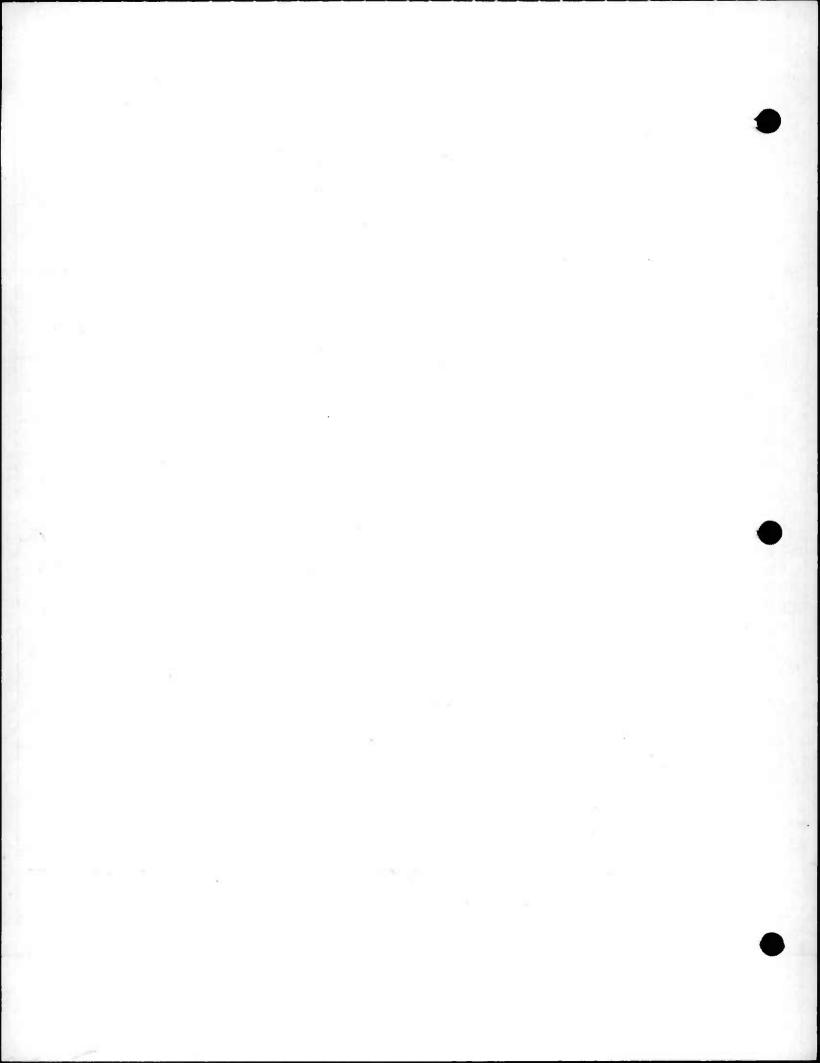


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	1. DECEDENT'S NAME (First		17						2. DATE OF DEATH	DAY	3. TIME OF DEATH
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	4. SOCIAL SECURITY NUME			IGE (In yrs. les	t birthday)	IF UNDER 1 YEAR	-	R 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		6. BIRTNPLACE (State or Foreign Country)
	3.30 10.32.14 R - 8.782				YRS.			MIN.	SEPT.24.	1912	WASHINGTON D.C.
_	9a. FACILITY NAME (If not in	stitution, give s	street and number)			9b. CITY, TOW	N OR LOCAT	ION OF DE	ATN Februar	9c. CO	UNTY OF DEATH
OR	CARRIAGE HI	LL NU	RSING HOME				ETHESI			/	ONTGOMERY
딩	RESIDENCE OF DEC	10b. COUNT	~		T 40. 0.7						
DIRECTOR	MARYLAND					Y, TOWN OR LO	CATION				10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	MUNIC	GOMERY		BE	THESDA					1X YES 2 NO
FUNERAL	The second second	mo rem	NT				10f. ZIP COD	_		10g. Cl	TIZEN OF WHAT COUNTRY?
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B	3 Widowed 4 Divo		IF YES, GIVE WAR (R DATES		1 🗆 '	ES 2 X NO	Specify:			Specify WHITE
ETED.	15, DEC	EDENT'S EDU	CATION	16a. DE	CEDENT'S	USUAL OCCUP	TION		16b. KINO OF E	I ISINESS/IN	
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릴	, , , , , , , , , , , , , , , , , , , ,		+5	ADMI	NIST	RATIVE	OFFIC	ER			
COMPL	17. FATHER'S NAME (First, M	iddle, Last)							NE (First, Middle, Maid	n Sumamal	
	GEOR	GE E.	POTTER, SR						HOLLAND		
B	19a. INFORMANT'S NAME (7)		-		. MAILING	ADDRESS (Stre			oute Number, City or T	own State 7	'in Code)
임	ANGELA POT	TER							WASHINGTO		
	20a. METNOD OF DISPOSITI	ON				OF DISPOSITION		1.11.			- City or Town, State
	1X Buriat 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other			cametery, crei	matory or o				7/17 WAS		
	21. SIGNATURE OF PUNERA	L SERVICE LI			TARI			SS OF FAC	JOSEPH	GAWI	LERS SONS
	* Hul	M.	Yetex	/							ASHINGTON D.C.
	23. PART I. Enter the di	seeses, or	complications that car	sed the de-	eth. Do r	not enter the	node of dy	ing, such	ss cerdiec or rea	piratory e	rreat, Approximete
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CERTIFICATION	csuse. Enter UNDERLYi CAUSE (Disease or inju	NG	c.								
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Ö	PART ii. Other aignifica	nt condition	In contributing to deal	h hut not m	noultino i	n the medeat		-1 1- #			
MEDICAL	Transit algunion	THE CONDITION	- contributing to dear	n but not re	esuiting i	n the underly	ing cause (given in F	Part I. 24a. WAS A	N AUTOPSY ORMED?	AVAILABLE PRIOR TO
ă									1 [] YES	2 NO	COMPLETION OF CAUSE OF DEATN?
×										••	1 🗀 YES 2 🗀 NO
ä			RIBUTE TO CAUSE					ERTAIN			
PHYSICIAN	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. PLACI	E OF DEAT	N (Check only or OTHER:	e)				
ΥS	1 TES 2 NO		1 - Inpatient 2 - ERA		□ DOA	4 Nursing H	ome 5 🗆 Re	esidence 6	Other (Specify)		
표	27. MANNER OF DEATN	Dandles	26a. OATE OF INJU (Month, Day, Ye		26b. TIMI INJ		NJURY AT WORK?		26d. DESCRIBE HOW	INJURY OC	CURED
B		Pending nvestigation					YES 2	NO			
	3 Suicide 6	Could not be	28e. PLACE OF INJ building, atc. (URY — At hor Specify)	na, tarm, a	treet, tectory, or	fice		261. LOCATION (Stree City or Town, Stat	t and Numbe	or or Rural Route Number,
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COMPLETED	29a. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the best of my k	nowledge, des	ith occurre	d at the time, d	its and place	, and due t	o the cause(a) and m	enner as ats	ated.
ŏ.											the cause(a) and manner as stated.
	296. SIGNATURE AND TITLE			G1 20				ENSE NUMI			
BE	1/1	2/-	1/1/1	27	ch /	119	47	111	170	1	SIGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF	PERSON WN	O CHELETED CAUSE OF	DEATH (ITEM	27) (Tvpa	Print)		O Y	117	14	44.7 1475
	JAMES J. FO	STER	M.D. 5530	WISC			#925	CHEVY	CHASE,	MD. 2	0815
	31. DATE FILED (Month, Day, 1	3 1995	32 REGISTRAR'S S	IGNATURE	all						

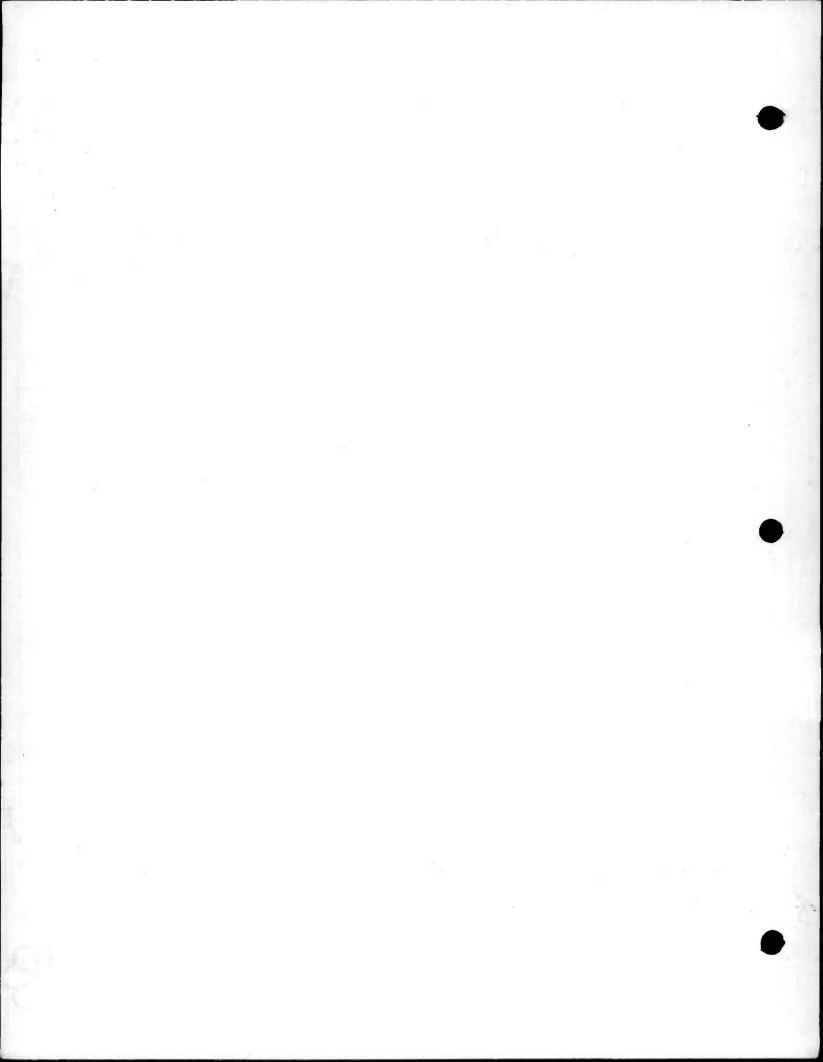


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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN YEAR Helen July 17, Pundt 1995 6:45 A M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIFTIN (Month, Day, Year IF UNDER 24 HRS. 6. BIRTNPLACE (State or Foreign 1 M 2 F DAYS HOURS 484-32-5059 YRS. 92 Feb. 1,1903 New York Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN DIRECTOR Carriage Hill Nursing Center Silver Spring Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring permit. 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit 9101 Second Avenue 20910 U.S.A. executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuban, Mexican, Puerto Ricen, etc.)
 T YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 🖾 Never Married 2 🗌 Merried IF YES, GIVE WAR OR DATES ВҰ 3 Widowed 4 Divorced Specify: White 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) Editor & Home COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY American Home Economics Elementery/Secondary (0-12) College (1-4 or 5+) 4 Economics Journalist Association once. 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ₹ Adolph E. Pundt BE Elisabeth Scharpf notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ralph C. Schutt, Jr. Albrighton Court Longwood, Florida 32779 pe 20e. METNOD OF DISPOSITION
1 ☐ Burlel 2 ⚠ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must cemelery, cremelory or other place)
Metropolitan Crematory 7/18/95 Alexandria, Virginia 4 Donetion 5 Other (Specify) medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. then 500 University Blvd.,W. Sil.Spr.,MD 20901 the 23. PART I. Enter the diseasea, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, and completely filled in by burial, cremation, or remo ahock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onaet and Death the disease or condition event, 1 Aspiration of Stomach Contents into Lungs resulting in death) Day Senile Dementia of the Alzheimers Type CERTIFICATION Years Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): prior to certificate has been signed by the attending physician on the State Dept. of Health and Mental Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING other 1 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST 6 PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? law requires that any 1 TYES 2X NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) **EXAMINER?** HOSPITAL: OTHER:
4 🖾 Nursing Nome 5 🗆 Residence 8 🗆 Other (Specify) 1 YES 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. MANNER OF DEATN 28b. TIME OF 28e. DATE OF INJURY with t 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED Is marked, 1 X Natural 5 Pending DIRECTOR: After the hours after death vitem 28 is mari В 1 YES 2 NO Investigation 2 Accident 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be LETED 4 Nomicide 29e. CERTIFIER 1 🔀 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end menner ee stated. COMP FUNERAL I Ξ 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) and menner ex stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7. NATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) Kevess-033159 Cohen 95 2 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) Ruth Kevess-Cohen, M.D. 8700 Georgia Avenue #400 Silver Spring, Maryland 20910 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

Davidson Romall

1111 1 9 1995



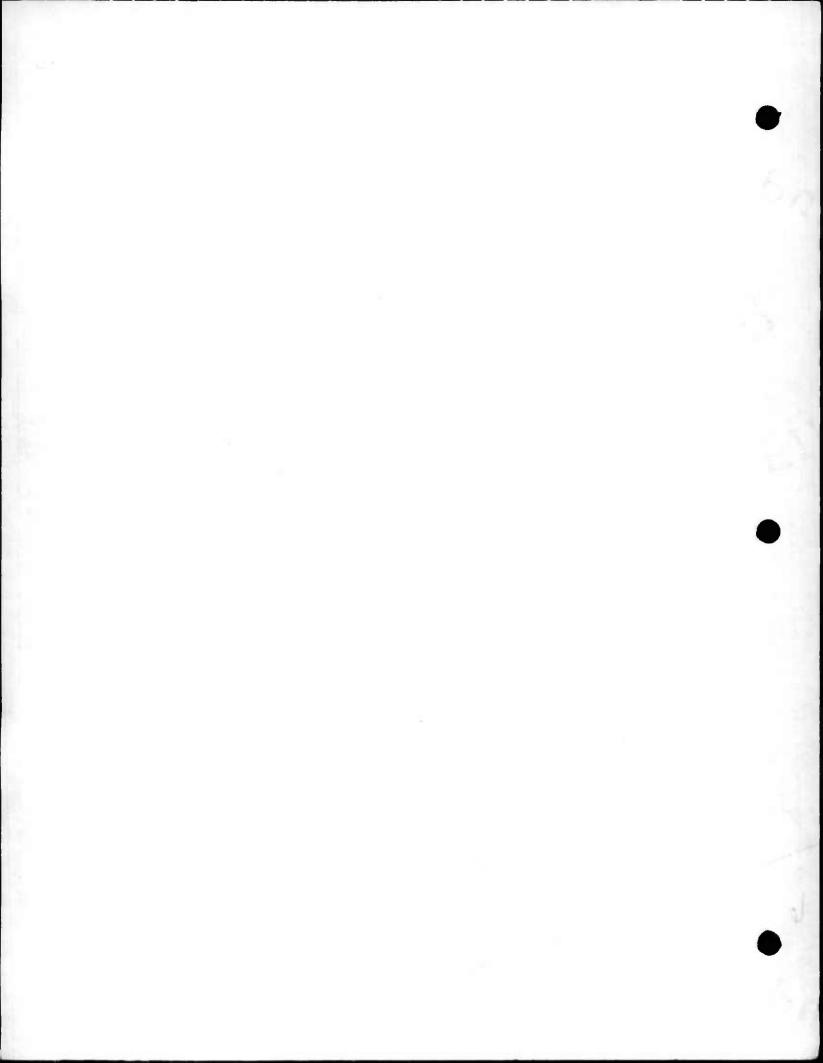
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Anours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF N				F HEALTH AND	MEN	ITAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)						2. 1	DATE OF DEATH	,		3. TIME OF OEATH
	Vivian A. Post							July 18	AY 100	YEAR	4:30PM M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER 1 YE		ATE OF BIRTH	<u>, 199</u>	8. BIRTH	PLACE (State or Foreign	
	213-28-6656	YAS.	MONTHS DA	YS HOURS MIN.		Month, Day, Year) uly 21,1	Country)				
	9e. FACILITY NAME (If not institution, give st		9b. CITY, TO	WN OR LOCATION OF		ury zri	9c. COUN				
DIRECTOR	14100 Berryville I		Germ	antown			Mont	gome	ery		
Ä	10s. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR L	OCATION					10d. INSIDE CITY
	Maryland Monte	gomery		Ger	mantow	n				- 1	LIMITS? 1 YES 2 NO
AL	10e. STREET AND NUMBER					101. ZIP CODE			10g. CITIZ	EN OF W	HAT COUNTRY?
FUNERAL	14100 Berryville	Road				20874			Unit	ed	States
5	11. MARITAL STATUS	12. WAS DECEOEN	T EVER IN U.S. AI		13. WAS	DECENDENT OF HISP	ANIC O	RIGIN? (Specify Ye		14. RACE	— American Indian, White, stc.
PY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE W		NO		i, specify Cuban, Maxi YES 2 X NO Spec		arto Hican, etc.)		Speci	ly:
	15. DECEDENT'S EDUC	2471011									White
	(Specify only highest grade	completed)	(0	ECEDENT'S Give kind of v n. Do NOT us	VSUAL OCCU	PATION g most of working	ı	16b. KIND OF BU	SINESS/INDI	JSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5 -	·) =		r Desi	anox		Interio	n Dog		tina
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		111	rerro	I Desi		AME /F	irst, Middle, Maiden		OLA	cing
	William Groth								,		
BE	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (St	victor et and Number or Rurs		Mitchel:		Codel	
2	Thomas E. Post		1								land 20874
	20e. METHOD OF DISPOSITION	300 Ne2 200				Jüly 22,			CATION — C		
	4 Donation 5 Other (Specify)	wai from State	Darne	smatory or of stown	Presk	yt. Churc	h C	em. Da	rnest	own,	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22. NAM	E AND ADDRESS OF I	ACILIT	Robert .	A. Pui	nphr	ey Funeral
	3/201/	POMA	▲ M	00803		/Rockvill					
	23. PART I. Enter the diseases, or c	omplications tha			274 67	mode of dylon su					Approximate
	snock, or heart failure. I	ist only one cau	se on each line	.	or ornar title	mode of dying, ou	011 00	ouronac or reap	actory acre	ret,	Intervel Between
	iMMEDIATE CAUSE (Finsi disease or condition										Onset and Death
	resulting in death)		ian Can		j:						
z											i i
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO	(OR AS A CONSE	QUENCE OF	7:						
2	ceuse. Enter UNDERLYING CAUSE (Disesse or injury	<u> </u>									
H	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	OUENCE OF	7:						
H H	rosalting in death) Exist	1.									
	PART II. Other significant conditions	contributing to	deeth but not	resulting i	n the under	ying ceuse given l	n Part	i. 24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
2								PERFOI			AMILABLE PRIOR TO COMPLETION OF CAUSE
밀								1 1 123 2	1-1-40		OF DEATH? 1 YES 2 NO
=	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEA	TH YE	S 🗆 NO	XX UNCERTA	IN C	ı			
4 1											
7 II	25. WAS CASE REFERRED TO MEDICAL		26. PLA	E OF DEAT	n (Crieck brilly	one)					
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	HOSPITAL:	1302		OTHER:	one) Home 🎖 Rasidenca	8 🗆	Other (Specify)			
PHYSICI	EXAMINER? 1 ☐ YES 2 ☑ NO 27. MANNER OF DEATH	1 Inpatient 2 I	ER/Outpatient 3	DOA 28b. TIM	OTHER: 4 Nursing	Home K⊠ Rasidence INJURY AT	_	Other (Specify) DESCRIBE HDW I	NJURY OCC	URED	
BY PHYSICIAN: MEDICAL	EXAMINER? 1 ☐ YES 2 🔀 NO	1 Inpatient 2 28a. DATE OF (Month, Di	ER/Outpatient 3 INJURY ay, Year)	DOA 28b. TIMI	OTHER: 4 Nursing E OF 28c URY M 1	Home X Residence INJURY AT WORK? YES 2 NO	_		NJURY OCC	URED	
B	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigation 3 Suicide 8 Could not be	1 Inpatient 2 28a. DATE OF (Month, Di	ER/Outpatient 3	DOA 28b. TIMI	OTHER: 4 Nursing E OF 28c URY M 1	Home X Residence INJURY AT WORK? YES 2 NO	28d.				oute Number,
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B	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigation 2 Accident investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only)	28a. DATE OF (Month, Did building, DIAN: To the best of	ER/Outpatient 3 INJURY ny, Year) F INJURY — At he atc. (Specify) my knowledge, de	28b. TIMI INJI	OTHER: 4 Nursing E OF 28c URY M 1 treet, factory,	Home	28d.	DESCRIBE HOW I	and Number o	or Rural R	oute Number,
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E COMPLETED BY	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINES	28a. DATE OF (Month, Di 28a. PLACE OI building,	ER/Outpstlant 3 INJURY my, Year) F INJURY — At he atc. (Specify) my knowledge, detamination and/or	28b. TIMMINJI 28b. TIMMINJI 28b. TIMMINJI 28b. TIMMINJI 18	OTHER: 4 Nursing E OF 28c URY M 1 treet, tactory, d at the time, n, in my opinic	Home & Residence INJURY AT WORK? YES 2 NO office date and place, and de n, death occured at the 29c. LICENSE NI 350604	28d. 28t. 28t. 28t. 28t. 28t.	DESCRIBE HOW I LOCATION (Street City or Town, State) a cause(a) and mandate and place, an	nner as state d due to the	d. cause(a) SIONED	and manner as stated.
BE COMPLETED BY	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only 0ne) 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRÉSS OF FERSON WHO	28a. DATE OF (Month, Date of e) 28a. PLACE Of building, 28a. PLACE Of building, 28a. PLACE Of building, 28a. PLACE Of building, 28a. PLACE Of building, 28a. PLACE Of building,	FINJURY — At he atc. (Specify) my knowledge, de amination and/or E of DEATH (ITE	28b. TIMMINJI 28b. TIMMINJI when term, a path occurre investigation	OTHER: 4 Nursing E OF 28c URY M 1 treet, tactory, d at the time, n, in my opinic	Home F Residence INJURY AT WORK? YES 2 NO office date and place, and dun, death occured at th	28d. 28t. 28t. 28t. 28t. 28t. 28t. 28t. 28t	DESCRIBE HOW I LOCATION (Street City or Town, State) a cause(a) and mandate and place, an	and Number of	d. cause(a) SIONED	and mannar as stated. (Month, Day, Year)
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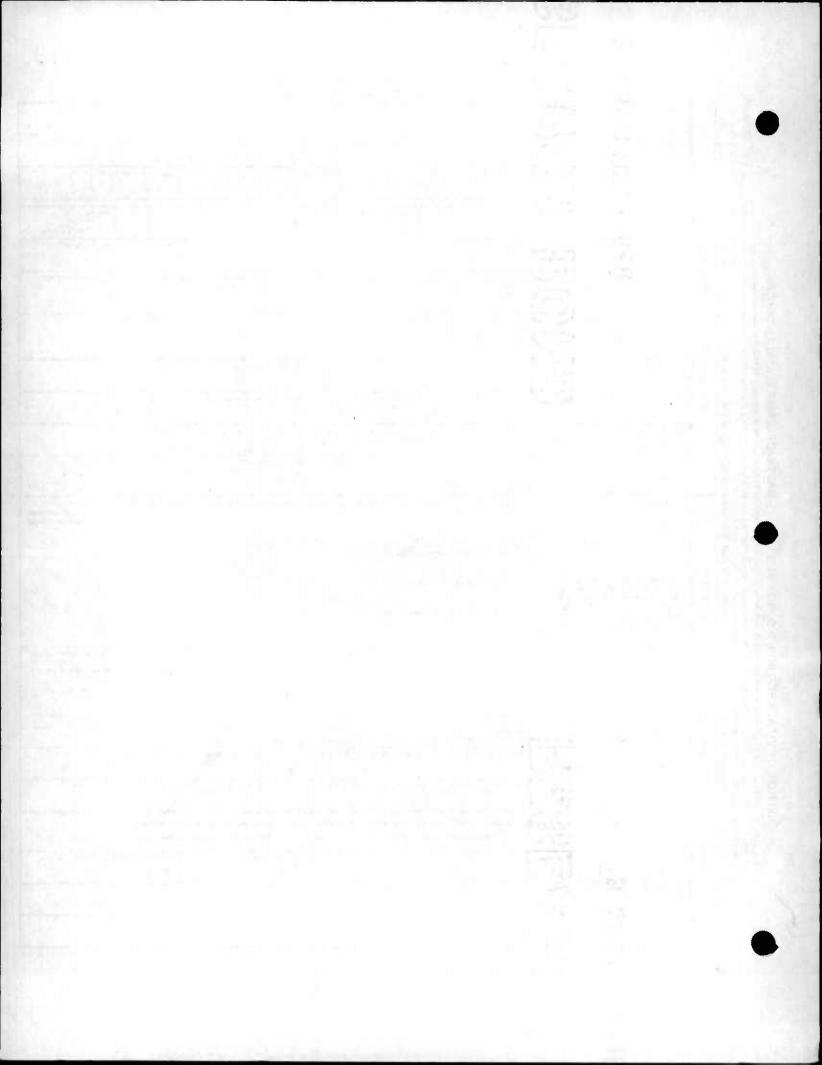


DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a floring after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

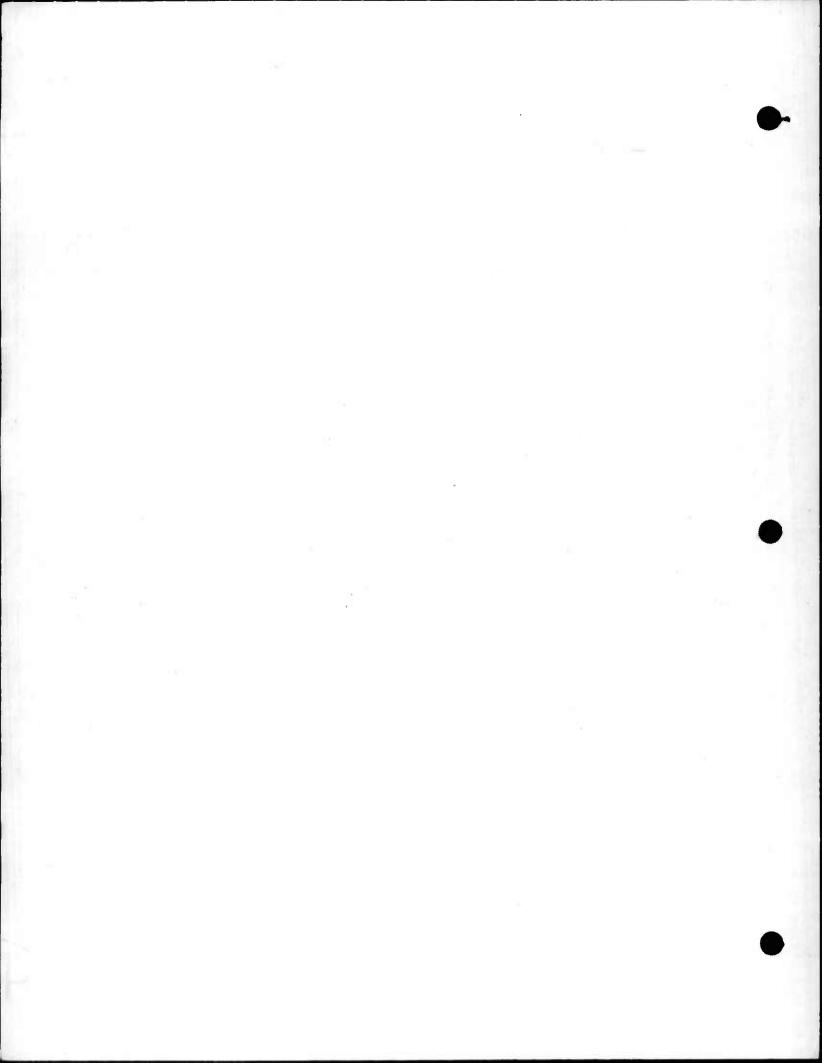
1 - STATE REGISTRAR			DEPARTMENT RTIFICAT			MENTA	REG. NO.			
DECEDENT'S NAME (First, Middle, Last	Kyung S		aek			July	of DEATH	199	95 ^{EAR}	9:55 P.
4. SOCIAL SECURITY NUMBER 216-25-6481	1 - M 2 XX	AGE (In yrs. last	YRS. MONTH		IF UNDER 24 HRS. HOURS MIN.	Sep	of BIRTH t. 26, 1	950	Countr	PLACE (State or Foreign th Korea
9a. FACILITY NAME (If not institution, given 5266 Cedar Lane				Colur	n LOCATION OF bia	DEATH			NTY OF D	
10a. STATE 10b. COUL HOW	ard		10c. CITY, TOWN	mbia	ION					10d. INSIDE CITY LIMITS? 1 YES 2XX NO
100. STREET AND NUMBER 5266 Cedar Lane	, #165			101	ZIP CODE 2104	14			izen of v	VHAT COUNTRY?
11. MARITAL STATUS 1 Nover Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT (FORCES? 1 FYES, GIVE WAS	YES 2 VINT	DED 1	If yes, sp	ENDENT OF HISP polify Cuban, Maxi	can, Puerto	N? (Specify Yaa Rican, etc.)	or No—	14. RACE Black Speci	- American Indian, White, atc.
15. OECEOENT'S El (Specify only highest gra Elementary/Secondary (0-12)		(Give	ECENT'S USUAL of kind of work dor of NOT use retired USEWIFE	e during ma (.)	IN st of working	164	domest		DUSTRY	
17. FATHER'S NAME (First, Middle, Last) Bong Ki Park					18. MOTHER'S I	, ,	Middle, Maiden Han	Sumame)		
19a. INFORMANT'S NAME (Type/Print) Hun Cho		19b.	4216 Po	ss (Street a Owder	Mill R	oad E	ber, City or Town Beltsvi	n, State, Zip 11e,	Md.	20705
20s. WETHOD OF DISPOSITION 1.1.1 Surface 2 Cremation 3 Re 4 Donation 5 Other (Specify)	imoval from State	cometee: erem	ID DATE OF DISP		me of Park Jul	y19,19		cation —		and the same of th
21. SIGNATURE OF FUNERAL SERVICE	- BOOKNO	int.	Z L	2. NAME AP Onal	V. BOI	FACILITY CGWar	dt Fun	eral	Home	
Immediate cause (rinal disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Z'/243.
PART II. Other significant conditi	ons contributing to de	eath but not re	suiting in the	underlyln	ceuse givan i	n Part I.	24a. WAS AN		24b.	WERE AUTOPSY FINDING
	7.7						PERFOR			MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Outpatient 3	OOA OTH	ER:	ACE OF DEATH (
27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28s. OATE OF IN (Month, Day,		28b. TIME OF INJURY M	28c. INJ WO 1 1	URY AT RK? ES 2 NO	28d. DE	SCRIBE HOW II	NJURY OC	CURED	
3 Suicide 6 Could not be determined	28s. PLACE OF I building, st	INJURY — At hom c. (Specify)	e, farm, street, fi	ectory, offic		28t. LOC City	CATION (Street a or Town, State)	and Number	or Rural F	loute Number,
Tondon dring	YSICIAN: To the best of m) and manner as stated.
Two areas are as a second	DER /				29c. LICENSE N			29d. DAT		(Month, Day, Year)
296. SIGNATURE AND TITLE OF CERTIF	elubbo m	1)			D38	304			will	8 1995
Michelias Wilson	WHO COMPLETED CAUSE TRELIAKUS			luxen		Coll	mlia	me	210	8 1995



TO BE COMPI	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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ten	n4,Film726,8/	11/95,lt							95	23420		
	1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR	TMENT OF	F HEALTH A	ND MENT	AL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle					J. DEATI	2. DA	TE OF OEATH	W 1	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	GRACE McM						uly 18	, 1995	10:00 A M		
	262- 34 -8466	96							BIRTNPLACE (State or Foreign Country PENNSYLVANIA			
œ	98. FACILITY NAME (If not institution SUBURBAN H)					WN OR LOCATION				Y OF DEATH GOMERY		
20	RESIDENCE OF DECEDER			BIHEODA			FIONT	JOHEKI				
DIRECTOR		NTGOMERY			y, town or lo THESDA					10d. INSIDE CITY LIMITS? 1 YES 2 1 NO		
FUNERAL	100. STREET AND NUMBER 5101 RIDGEFIE	LD ROAD				101. ZIP CODE 20816			U.S.	N OF WHAT COUNTRY?		
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Vidowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	TEVER IN U.S. AR YES 2 1	IMED NO	If yes	DECENDENT OF , specify Cuban, YES 2 NO	Mexican, Puar	GIN? (Specify Year to Rican, etc.)		I. RACE — American Indian, Black, White, etc. Specify: WHITE		
LED	15. DECEDENT' (Specify only highes	S EDUCATION t grade completed)	(G	ive kind of v	USUAL OCCUP	ATION most of working	1	6b, KIND OF BUS	SINESS/INDUS	TRY		
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5	+))MEMA	200-01-100			OWN HO	ME			
BE CO	17. FATNER'S NAME (First, Middle, La SAMUEL MCM	ILLEN				16. MOTNE LAUR		t, Middle, Malden :	Surname)			
TO B	190. INFORMANT'S NAME (Type/Print MARJORIE P. WI)							DA, MD.				
	20e. METHOD OF DISPOSITION 1 General 2 Commetter 3 General Commetter Specify				Posposition	(Name of EMATORY				y or Town, State		
	21. SIGNATURE OF FUNDIAL SERV			_	_			ONS, IN		20016		
	> Veinou	Sim	nons	2	5130	WISCON	SIN AV	E. N.W.	WASH	INGTON, D.C.		
	23. PART I. Enter the disease ahock, or heart fe iMMEDIATE CAUSE (Finsi disease or condition resulting in death)	Bacteri	al seps	is		mode of dying	, such aa c	erdisc or reepi	ratory erres	t, Approximata Interval Between Onset and Desth		
NO	DUE TO (OR AS A CONSEQUENCE OF): b. Bladder carcinoma Due TO (OR AS A CONSEQUENCE OF):											
CATI	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	DUE TO	(OR AS A CONSEC	DUENCE OF	う :							
CERTIFICATION	that initiated events resulting in deeth) LAST	DUE TO	(OR AS A CONSEC	DUENCE OF	7:							
빙	DART II Other significant con	ditions contained to the										
PHYSICIAN: MEDICAL	PART II. Other significent con	ditions contributing to	deeth but not r	eeuiting i	n the underly	ying ceuse giv	en in Part i.	24a. WAS AN A PERFORI	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?		
ME										1 TES 2 NO		
AN	DID TOBACCO USE CO				N (Check only o		RTAIN 🗆					
SIC	EXAMINER? 1 XYES 2 NO	HOSPITAL:	0.00		OTHER:	Iome 5 Rasid	lence 8 🗆 Ot	her (Specify)				
PHY	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF (Month, D	INJURY ay, Year)	28b. TIME INJI	E OF 28c.	INJURY AT WORK?		EŞCRIBE NOW IN	JURY OCCUP	RED		
ВУ	2 Accident Investiga	28e PLACE O	F INJURY At ho	me ferm e		YES 2 N	-	CATION (Comme				
ETED	4 Nomicide datarmir	building,	etc. (Specify)				C	ty or Town, State)		Aural Route Number,		
COMPLETED	(Check only one) 1 CERTIFYING CERTIFYING 2 MEDICAL EX.	PHYSICIAN: To the best of AMINER: On the bests of a	my knowledge, de: camination and/or i	sth occurre	d at the time, d	lete and place, er	nd dua to the d	cause(a) and mani its end place, end	ner as stated. I due to the c	euse(s) and manner as stated.		
BE	29b. SIGNATURE AND TITLE OF CEP	TIFIER				D24	SE NUMBER			y 18, 1995		
5	30. NAME AND ADDRESS OF PERSON BRIAN CHARLES	N WNO COMPLETED CAUS	SE OF DEATH (ITEM			#1 WASI	HINGTO	N DC 20	009-25	529		
	31. DATE FILED (Month, Day, Year)	32 REGISTRA	R'S SIGNATURE	01								
	JUL 21 1995	Julia dikurite	Redall									

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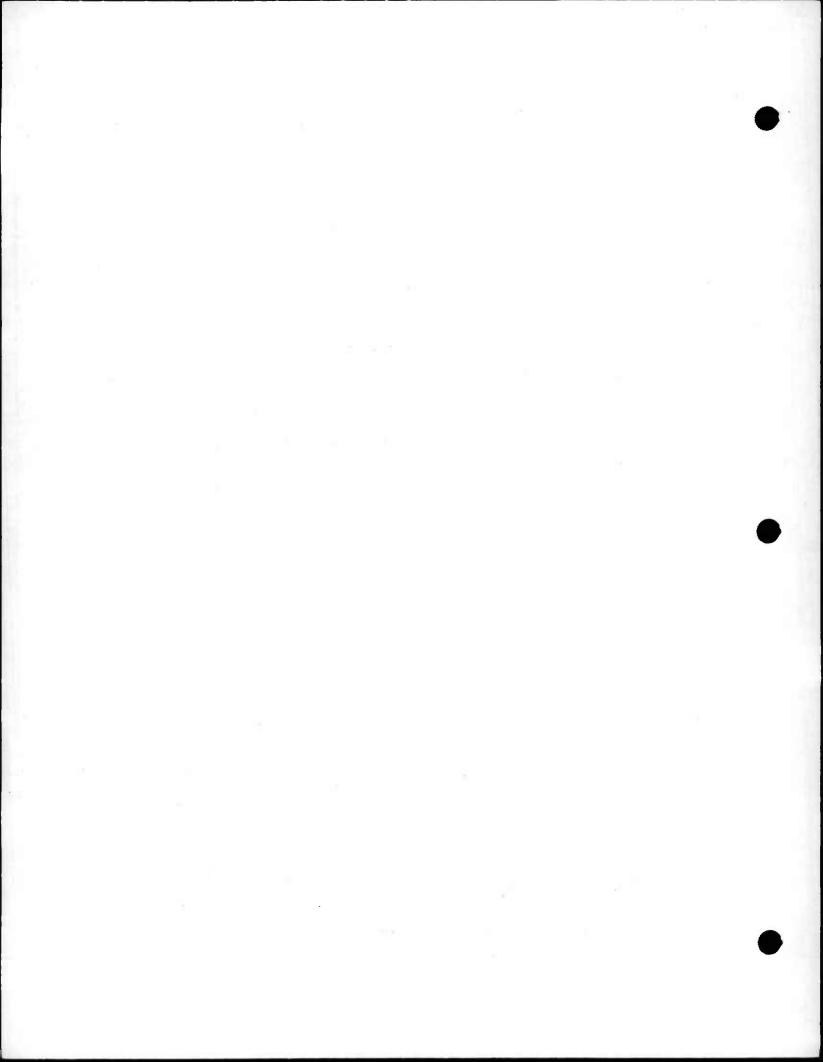


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death centificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

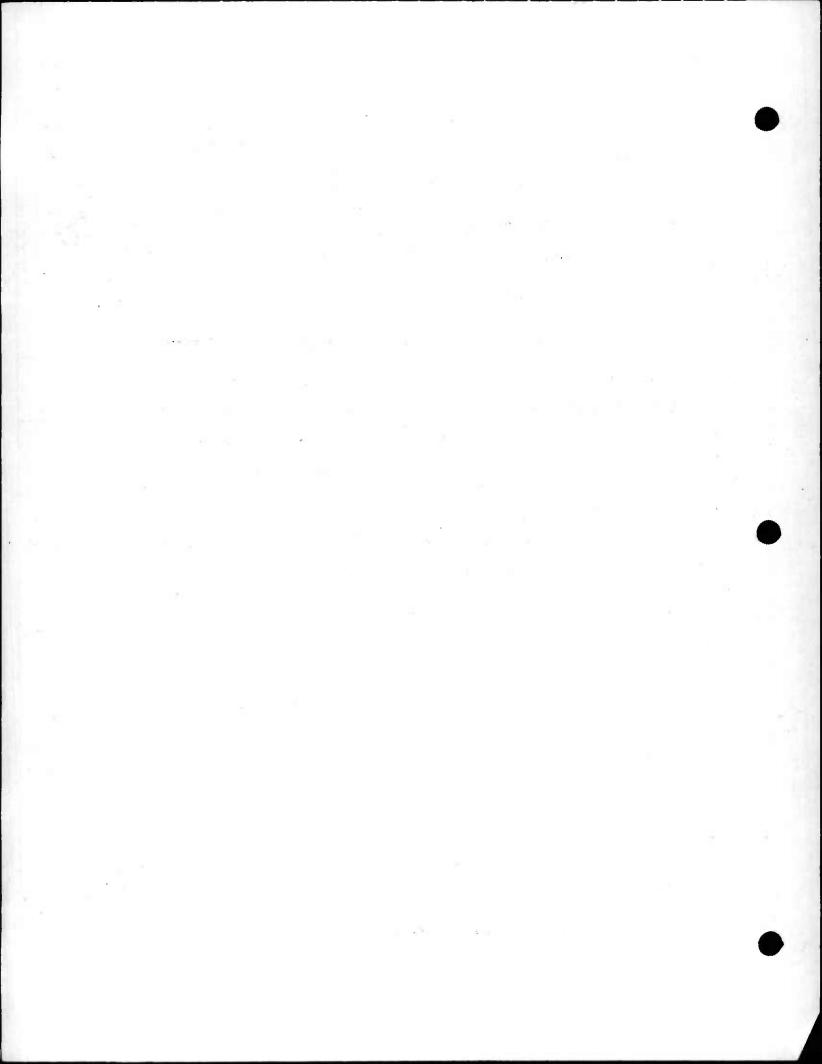
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IMPORTANT: If term 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLAN		MENT OF H		MENTAL HYGIE			20 1 lag	•
	1. DECEOENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3.	TIME OF DEATN	
	JAMES	LEE		P	ARKE	JULY	1 1	95 5	5:44	P.M
			rrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		B. BIRTHPLA Country)	CE (Stete or Fore	ilgn
			34 YRS.			May 1, 1	961	Mary1	and	
<u>~</u>	9e. FACILITY NAME (If not institution, give street	t end number)		9b. CITY, TOWN C	R LOCATION OF D	EATH	9c. COUNT	9c. COUNTY OF DEATH		
DIRECTOR	ANNE ARUNDEL GEI	ITAL	ANNAP	OLIS		ANNI	E ARI	JNDEL	_	
뿐	100. STATE 10b. COUNTY			TOWN OR LOCAT				100	I. INSIDE CITY	
	Maryland Montg	omery		Damascu					YES 2XX N	10
RA	9928 Colorado Cour	. 4		101	. ZIP CODE	0	10g. CITIZI		COUNTRY?	
FUNERAL		2. WAS DECEDENT EVER IN U.	S. ARMED	t3 WAS DEC	2087	NIC ORIGIN? (Specify	for our No	USA	American Indian	
BY FE	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES :	2X XNO	it yes, sp	2XXNO Specia	n, Puarto Rican, atc.)	or No —	Black, Wi	White	
	15. DECEDENT'S EDUCAT	ION 18	. DECEOENT'S U	SUAL OCCUPATION	DN .	185 KIND OF I	USINESS/INDU	CTDV	WILLE	
E	(Specify only highest grade con Elementary/Secondary (0-12)	mpleted) College (1-4 or 5+)	(Give kind of wo	ork done during mo retired.)	st of working	TOOL KIND OF I	03111233/11100	əini		
로	11th		Mech	anic			Automol	oile		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Meid	en Surname)			
BE	Allison R.	Parke				ildred Vi			3	
P	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or 1				
1	Allison R. Parke			Box 116		cus, Mary				
	20a. METHOD OF DISPOSITION 1 Burlel	I from State 20b. PL cametei	ACE AND DATE OF	POISPOSITION (Na er place)	me of	OATE 20c.	OCATION — CI	ty or Town,	State	
	21. SIGNATURE OF FUHERALISERVICE LICENS	SEE ME	CLODOLL	22. NAME AN	D ADDRESS OF FA	-10-95 A	Lexandr	ria, \	Virgini	a
	> Volor Flator			Georg	ge P. Kai	las Funer				- 1
	23. PART i. Enter the diseases, or com	collections that caused the	a deeth De se	6160	Uxon Hi	11 Rd. Ox	on Hill	, Md		
	anock, or heart failure. List	t only one cause on each	ilne.	it enter this mo	de of dying, suc	n ss cardiac or res	piratory arres	Bt,	Approximat interval Bat	ween
1	iMMEDIATE CAUSE (Finei disease or condition	MILITIDIE	(N) 101	RISC					Onest and	Death
	resulting in death) a	MULTIPLE DUE TO (OR AS A CO	INSEQUENCE OF)	Mices						_
N	Sequentially list conditions, b									
AT	If sny, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	INSEQUENCE OF)							
FIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	INSEQUENCE OF							
CERTIFICATION	resulting in death) LAST							į		- 1
	PART II. Other significent conditions of	ontributing to death but	- ct	Ab d - d - d - d						
CAL	ottor organizations of	ontributing to deetil but i	not readiting in	the underlying	cause given in	PERF	N AUTOPSY DRMEO?	AVA	RE AUTOPSY FINE	
MEDI						1 XYES	2 NO	OF	MPLETION OF CAI DEATH?	
	DID TOBACCO USE CONTRIB	UTF TO CAUSE OF I	DEATH YES		UNCERTAI	N [1/2	YES 2 NO	·
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26.	PLACE OF DEATN		OTTELKIAN					-
Sic		OSPITAL: Inpatient 25 ER/Outpatie		OTHER:	5 - Residence	6 Other (Specify)				
돌	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	_	JRY AT	28d. DESCRIBE NOV			FIXED O	BILL
BY	1 Netural 5 Pending 2 Accident Investigation	7/11/95	1638	PM 1 🗆 Y	ES 2 NO	DRIVER OF	- DUTO 11	Uvou	DIN CO	HISI
8	3 Suicide a Could not be	28e. PLACE OF INJURY — building, etc. (Specify)		eet, factory, office		28t. LOCATION (Street City or Town, Sta				
			STREET			GOVERNOR'S	BRINGE	RDA	PATUXEN	TRD
COMP	29e. CERTIFIER (Check only one)	N: To the best of my knowledg	e, death occurred	at the time, date	end place, end due	to the cause(e) end m	enner ee stated			
00	2 MEDICAL EXAMINER: 0	on the beele of examination en	d/or investigation,	In my opinion, de	ath occured at the	time, date end place,	and due to the	cause(s) and	l menner ee stat	ted.
BE	296. SIGNATURE AND TITLE OF CERTIFIER	ell. LA	. /		29c. LICENSE NUI		1 .		nth, Day, Year)	
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF PEATH	M	400	O.C.M	1.E.	▶ JU	JLY]	12,199	5
	MARIO FIGOLU				eet, Ba	altimore	, Mary	yland	1 2120	1
ij	31. DATE FILED (Month, Quy, Year)	32. REGISTRAR'S SIGNATU	RE							
· I										- 1



		1 - STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMENT OF H	EALTH AND MI	ENTAL HYGIENE REG. NO.	
			UDDD L.	PATE		MONTH DAY	1. 1995 1. 45 M
Pin		242-10-4387	SEX 6. AGE (In yrs. las	YRS. MONTHS DAYS	HOURS MIN.	1. DATE OF BIRTH (Month, Day, Year) 11/16/14	* BIRTHPLACE (State or Foreign Country) North CArolina
, 2, 3 should	TOR	9a. FACILITY NAME (If not institution, give atree OUTHERN RESIDENCE OF DECEDENT		1 01	NTON		E. COUNTY OF DEATH PRINCE GEORGES
permit. Pages 1	DIRECTOR	10e. STATE 10b. COUNTY	George's	Brandywine	ION		10d. INSIDE CITY LIMITS? 1 YES 2 X NO
Isit	IERAL	11805 Lusbys Lane		101.	ZIP CODE 0613	10	Dg. CITIZEN OF WHAT COUNTRY? USA
215-0020 attending physician. use as the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT, EVER IN U.S. AR FORCES? 1 X YES 2 I IF YES, GIVE WAR OR DATES WWII	IMED 13. WAS DEC	cify Cubari, Mexican,	ORIGIN? (Specify Yea or I Puerto Rican, atc.)	No- 14. RACE - American Indian, Black, White, etc. Specify: White
10 Pag 20	COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12)	npleted) (G College (1-4 or 5 +)	cedent's usual occupation for kind of work done during most Do NOT use retired.)	st of working	Military	
S E E	BE COM	17. FATHER'S NAME (First, Middle, Last) Lloyd B. Pate				(First, Middle, Meiden Sum	name)
MA retain 5 sho notifi	5	Madeline D. Procto	r 5	Bame as item			
		20a. METNOD OF DISPOSITION 1 Deurel 2 Cremation 3 Remova 4 Donation 5 Other (Specify) 21. SIGNATURE OF UNERAL SERVICE LICEN	I from Stata cemetery, cre	and date of disposition (National Date of Cemet	ery 7/19	/95 Golds	ion — city or Town, State boro, N.C.
bALIIMOKE, hours after death. Page 6 may be ed in by the funeral director, page or removal. medical examiner must be		Sur P. Ka	les b.	6160 0	xon Hill		ill, Md. 20745
ed within 24 ompletely fill cremation, event, the		23. RRRT I. Efter the diseases, of conshock, or heart failure. Lia IMMEDIATE CAUSE (Finel disease or condition resulting in death)	pilications that caused the det only one couse on each line	4	da of dying, such a	s cardiac or respirato	Approximate Interval Between Onset and Death
h certificate be saiding physician Hygiene prior to or other traur	CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa resulting in deeth) LAST	DUE TO (OR AS A CONSECUENT OF THE TO		7.0		8 Mes.
luires that the death isigned by the atter Health and Mertal in the was any injury, o	EDICAL (PART II. Other aignificant conditions of	ontributing to deeth but not r	eaulting in the underlying	Ceuse given in Pa	PERFORMED 1 YES 2	O? AMAILABLE PRIOR TO
e law req has been Dept. of 23 sho	Σ	DID TOBACCO USE CONTRIB		TH YES NO DE OF DEATN (Check only one)	UNCERTAIN		1 YES 2 NO
SICIAN: The certificate har the State D	PHYSICIAN:	EXAMINER?	OSPITAL: Inpatient 2 ER/Outpatient 3 28a. DATE OF INJURY	OTHER:	5 Residence 8		
this with with	ВҰ	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year) 28a. PLACE OF INJURY — At ho	M 1 V	ES 2 NO	Id. DEŞCRIBE HOW INJUR	
OR ATTENDING DIRECTOR: After hours after death tem 28 is ma	ETED.	3 Suicide 8 Could not be detarmined	building, atc. (Specify)			City or Town, State)	Number or Rurel Route Number,
対対な事	COMPLET	(Check only one) CEHTIFYING PRYSICIAL ONE) CEDICAL EXAMINER: (N: To the best of my knowledge, de				as stated.
TO THE HOSP TO THE FUNE TO THE WITHIN TO THE WITHIN	TO BE	298) SIGNATURE AND TITLE ON CERTIFIER	w	9.	29c LICENSE NUMBE	33	d. DATE SIGNED (Month, Day, Year)
9		30. NAME AND ADDRESS OF PERSON WHO CO	1 7 -	SUNNATTS	ROAD	CLINTO	ON MANJAND
		31. DATE FILED (Month, Day, Year) JUL 17 1995	32. REGISTRAR'S SIGNATURE	Corbe			71.00



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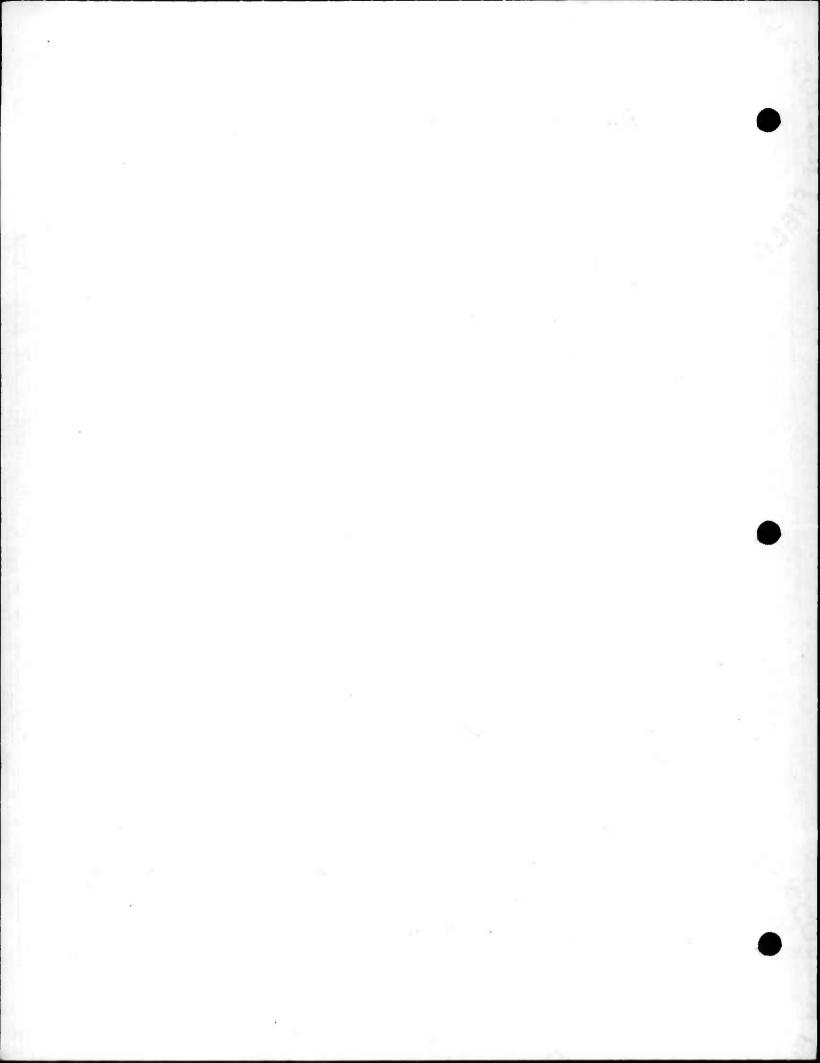
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ubus 31. DATE FILED (Month

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95 23423 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG NO 2. DATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATING owell) oro Hu 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTN (Month, Day, Year) 9 / 7 / 4 2 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 6. BIRTNPLACE (State or Foreign DAVE 1 🗌 M 2 🔀 F 52 577-56-8778 Virgini 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN DIRECTOR Prince George's Hospotal Center Prince George's <u>Cheverly</u> 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Prince George's Hyattsville 1 X YES 2 NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6711 Redfield Ave. 20784 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Mexicen, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 300 11 MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES BY 3 Widowed 4 X Divorced Black COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY most of working Elementary/Secondary (0-12) College (1-4 or 5 +) Dir. of Housekeeping 12th Nursing Home 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Wilmont Powell BE Jeanette Gales 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Robin Powell # 10 above Same as 20a. METNOD OF DISPOSITION
1 Duriel 2 Cremellon 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State ☐ Donation 6 ☐ Other (Specify) Landover, Md. Harmony Mem Park 7/15/95 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY H.S. Washington & Sons, Inc. "arry 4925 Burroughs Ave., N.E. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart fellurs. Liet only one cause on each line. Approximete Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease or condition hertenous cardiovosculas disense resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 - YES 2 - NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Inpetient 2 ER/Outo 4 - Nursing Name 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28b. TIME OF 28e. DATE OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED (Month, Day, Year, 1 Natural Pending ВҰ 1 YES 2 NO 2 Accident Investigation 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 290. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. (Check only one) MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. TURE AND TITLE OF LICENSE NUMBER BE 29d DATE SIGNED (Month, Day, Year)

FTED CAUSE OF DEATH (ITEM 27) (Type, Print) A



DIVISION OF VITAL RECORDS, P.O. BOX 68760

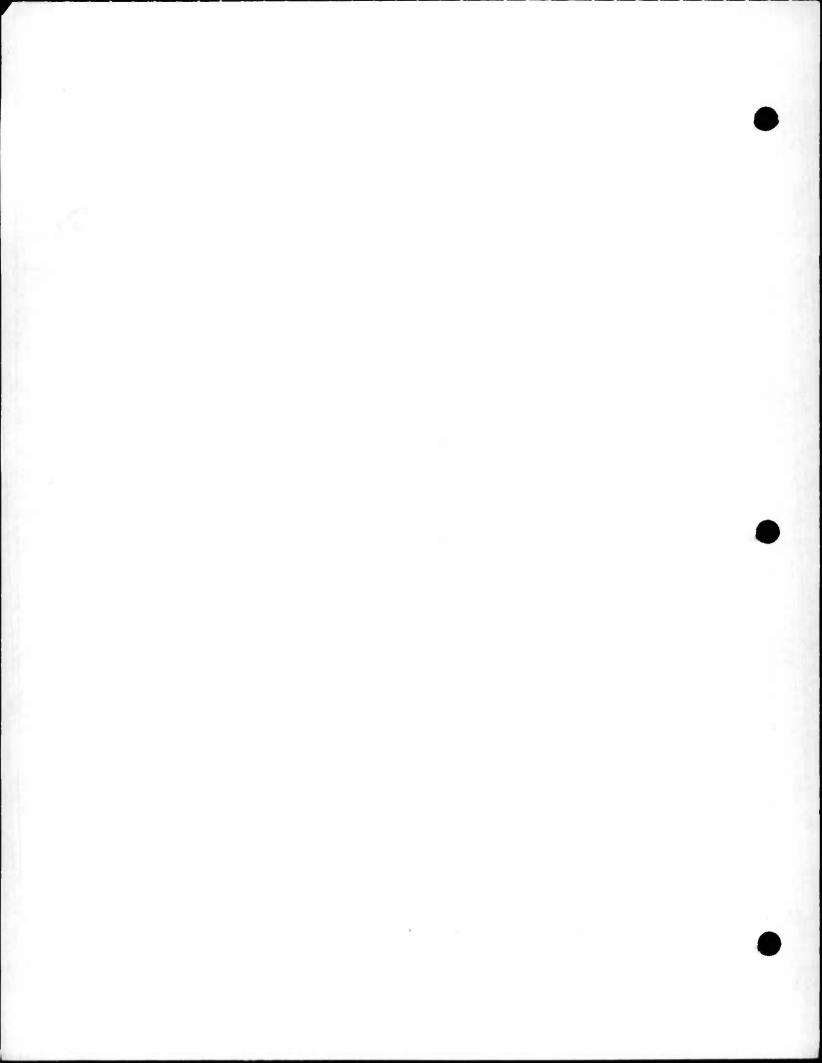
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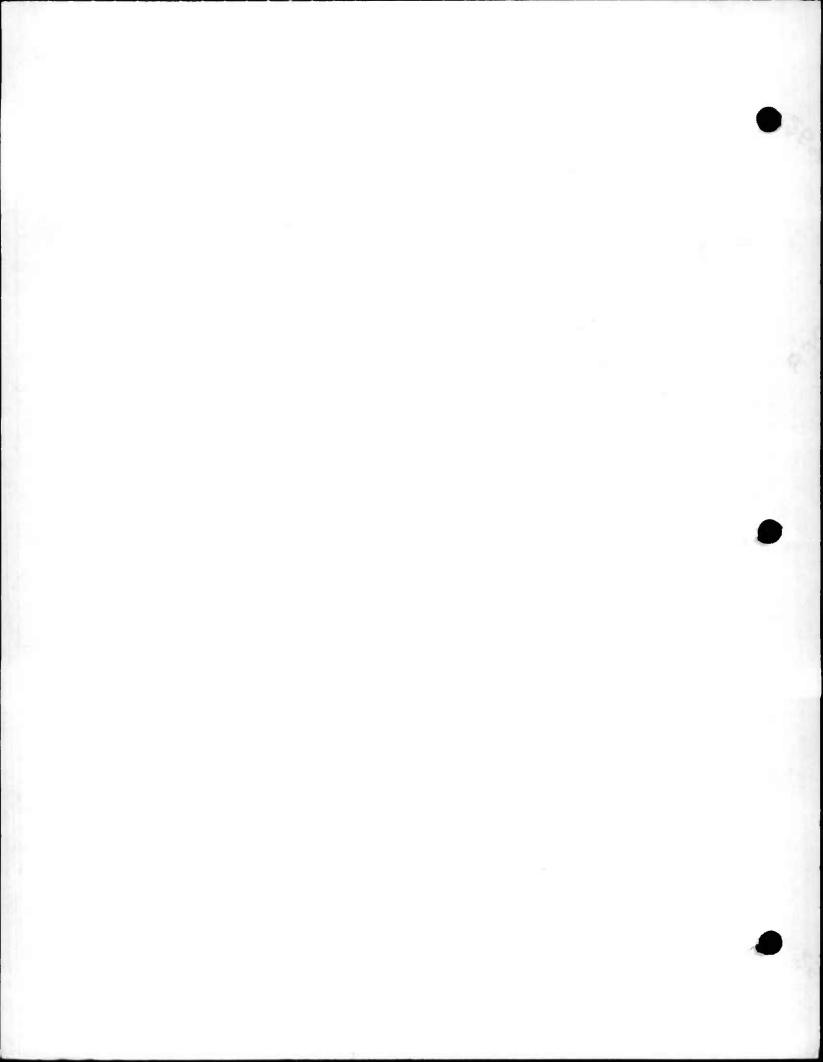
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - FOR STATE REGISTRAR	E OF MARYLAI	ND / DEPAR	TMENT OF	HEALTH AND	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH	<i>.</i>	3. TIME OF OEATH		
	Markham Payne					July 12,	1995 YEAR	9:15 A M		
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In	yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	a. BIRT	HPLACE (State or Foreign		
	710-14-0479 ¹⊠™	-	1 YRS.	MONTHS DAYS	HOURS MIN.	Sept. 10,	1903 V	irginia		
-	9e. FACILITY NAME (If not institution, give street and no	umber)		9b. CITY, TOWN	OR LOCATION OF D		9c. COUNTY OF			
DIRECTOR	Fairland Nursing Home	<u> </u>		Silve ₁	Spring		Montgomery			
띮	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10c CITY	. TOWN OR LOC	TION					
E C	Maryland Montgomer	v County						10d, INSIDE CITY LIMITS?		
7	100. STREET AND NUMBER	y country	1 31.	lver Sp	M. ZIP CODE		1 YES 2 K NO			
ER/	2101 Fairland Road				20904		1.00	Jnited States		
FUNERAL	11. MARITAL STATUS 12 WAS	DECEDENT EVER IN U	S. ARMED	13. WAS DE	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No.— 14. RACE —					
BY F	1 Never Merried 2 Merried IF YE 3 Widowed 4 Divorced			pecify Cuban, Mexic S 2 NO Speci	en, Puerto Rican, atc.)	Dia	ck, White, etc.			
								White		
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	1	Give kind of w life. Do NOT use	ork done during n	ION lost of working	18b. KIND OF BU	ISINESS/INDUSTRY			
ا ڌ		(1-4 or 5 +)				_				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	5+	Insuran	ce Agen		Insura:	nce Indus	stry		
	Warland Payne				Fannie		Surneme)			
BE	19e. INFORMANT'S NAME (Type/Print)	·	19b, MAILING	ADDRESS (Street						
임	19e. INFORMANT'S NAME (Typer/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) H. Dudley Payne 14 Main Street, Warrenton, Virginia 2218									
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town State									
	4 Donation 5 Other (Specify)	Fo:	ry, crematory or oth	oIn Cem	etery 7	/15/95 Bro	entwood,	Maryland		
	21. SIGNATURE OF FUNERAL SERVICE LICENSES	, ,,		22. NAME	ND ADDRESS OF FA	CILITY				
	> Track 4.	func	ey.			Funeral Ho		d, MD 20722		
	23. PART I. Enter the diseases, or complicat	ions thet cause	death. Do no	ot enter the m	ode of dying, suc	ch as cardiac pr resp	piratory arrest.	Approximete		
	shock, or heert fallure. List only iMMEDIATE CAUSE (Final	one ceuse on ead	ine.				,,	interval Between Onset and Death		
	disease pr condition resulting in death) Prostate Cancer									
	DUE TO (OR AS A CONSEQUENCE OF):									
Z	Sequentielly list conditions, b.									
¥ E	tif any, leading to immediate cause. Enter UNDERLYING									
은	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CO	ONSEQUENCE OF)·						
CERTIFICATION	resulting in deeth) LAST			,				j		
	0.									
ᇫ	PART II. Other significant conditions contrib		not resulting in	the underlylr	ig cause given in	Part i. 24s. WAS AN PERFOI		b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
ă	Congestive Heart	Failure				1 TYES	X NO	COMPLETION OF CAUSE OF DEATH?		
Σ	DID TODA COO LICE COA ITEMA							1 - YES 2 X NO		
AN	DID TOBACCO USE CONTRIBUTE 25. WAS CASE REFERRED TO MEDICAL					N 🗆 📗				
를 I	EXAMINER? HOSPI	TAL:	PLACE OF DEATH	QTHER:						
PHYSICIAN: MEDIC		DATE OF INJURY	28b. TIME		ne 5 Reeldenca	8 Other (Specify) 28d. DESCRIBE HOW	MINIST OCCUPED			
	1 Netural 5 Pending	(Month, Day, Year)	INJU		DRK?	200. DESCRIBE NOW	INJURY OCCURED	}		
ğ	2 Accident investigation 3 Suicide 8 Could not be	PLACE OF INJURY -	At home, tarm, st			281, LOCATION (Street	and Number or Rural	Route Number,		
	4 Homicide determined	building, atc. (Specify)				City or Town, State;)			
וו	29e. CERTIFIER (Check only 1 X CERTIFYING PHYSICIAN: To the	ne beat of my knowleds	e, death occurred	at the time, dat	end place, and due	to the causals) and ma	oper se sisted			
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the b							e) end manner es stated.		
Ŭ W	29b. SIGNATURE AND TITLE OF CERTIFIER	MBER		O (Month, Day, Year)						
m	The 11 /se	,			D2499			18, 1995		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLE	TED CAUSE OF DEATH	(ITEM 27) (Type, i	Print)	DETI	•	July	10, 1777		
\	Luis A. Casas 8	317 Cherr	y Lane	Laurel	, MD 207	07				
	31. DATE FILED (Month, Day, Year) 32/F	EGISTRAR'S SIGNATU								
	JUL 1 9 1995 Jul	UAL SURBINGEN	THE PERSON NAMED IN							



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		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPA CERTI	RTMENT OF H	HEALTH AND I	MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Last FIORENCE M		EID			2. DATE OF DEATN	DAY Y	3. TIME OF DEATN 95 6:00 p m
pin		4. SOCIAL SECURITY NUMBER 577-48-8725	1 🗌 M 2 🏋 F	(In yrs. last birthday) 59 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTN (Morth, Day, Year) MAY 12, 1	8.	BIRTHPLACE (State or Foreign Country) D. C.
1, 2, 3 should	TOR	9a. FACILITY NAME (If not institution, give HOLY CROSS HOS RESIDENCE OF DECEDENT	SPITAL			OR LOCATION OF DE		MON'	Y OF DEATH TGOMERY
nit. Pages	DIRECTOR	MD. M		10c. CI	SILVER	SPRING			10d. INSIDE CITY LIMITS? 1 X YES 2 NO
020 physiclan. burlal-transit permit.	FUNERAL	318 BURNT MILL				20901		UNIT	n of what country? ED STATES
9 g a	Β¥	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEOENT EVER IN FORCES? 1 _ YES IF YES, GIVE WAR OR DA	2 NO	13. WAS DEC	a or No- 14.	Bleck, White, etc. Specify: BLACK		
21 al or for u	LETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	DUCATION ide completed) College (1-4 or 5+)	(Give kind of life. Do NOT a		ost of working	16b. KIND OF BU		
MARYLAND 2 retained by the hospital 5 should be detached to notified at once.	COMPL	12 17. FATHER'S NAME (First, Middle, Lest) OLLIE LEE MORG	2 ANT CD	PROCU	JREMENT A	16. MOTNER'S NAM	ME (First, Middle, Maiden		NMENT
be retained by ge 5 should to notified a	TO BE	198. INFORMANT'S NAME (Type/Print) SHERAN F. REID				and Number or Rural R	E COLEMAN Route Number, City or Tow SILVER S		MD. 20901
may may		20e. METNOD OF DISPOSITION \$\int_{\sqrt{0}}\text{ Burlal 2 \sqrt{0} Cremation 3 \sqrt{0} Rei 4 \sqrt{0} Donation 5 \sqrt{0} Other (Specify) \sqrt{0}	emoval from State com	b. PLACE AND DATE	E OF DISPOSITION (Na		DATE 20c. LC	OCATION — City	y or Town, State
2 2 2 3 3		21. SIGNATURE OF FUNERAL SERVICE L	CIANS	131					
nin 24 hours afterly filled in by mation, or remote t, the medica		23. PART I. Enter the diseases, or shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	e. Listory on a course on e	d tha dasth. Do pach line.	not enter the mo	oda of dying, such	h ss cardiac or reap	iretory arrest	Approximate interval Between Onset and Death
P.O. BOX 68: n certificate be execute anding physician and co Hygiene prior to buria or other traumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST	Y/EV.						
S Deer H	MEDICAL	DID TOBACCO USE CON	te protection	3 d la	Bobs -	mellitu	PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
E # # # E	YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 202 NO	HOSPITAL:	patient 3 🗆 DOA		ne 5 🗆 Residenca I	8 Other (Specify)		
_ a = = E	ВУ РНУ	27. MANNER OF DEATH Netural 5 Pending 2 Accident Investigation			M 1 1	YES 2 NO	28d. OEŞCRIBE HOW I		
DIVISION OR ATTENDING DIRECTOR: After hours after deat	LETED	3 Suicide 6 Could not be determined		city)			261. LOCATION (Street : City or Town, State))	
E 25 E	COMPLETE	(Check only CERTIFYING PHY	SICIAN: To the bast of my knowle	n and/or investigati	red at the time, date ion, in my opinion, d	leath occured at the I	Ilme, date and place, an	nd due lo lhe ca	ause(s) and manner as stated.
TO THE HOSPI TO THE FUNER De filed within	TO BE	30 NAME AND ADDRESS OF PERSON W	A2005	OTEM 27) (For	- Calcul	D 05	SGA	29d. DATE SIG	IGNED (Morry), Day, Year)
,,		JAMUEL I	TU 6019 5	(031		DIP A	vo, Se,)	le 3a	6) ma 20903
7		JUL 21 1995	32 REGISTRAR'S OGN	Lett					



burial-transit permit. Pages 1, 2, 3 should

A	mended #6	7/19/95 1	MRT	mont	anneru	Count	4,95	23426			
	mended #6 FOR 1-STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	TMENT OF	HEALTH AND	MENTAL HYGIEN	IE /				
	1. DECEDENT'S NAME (First, Middle, Last)	ahad D-1	cliff	IOAIL OI	DEATH	2. DATE OF GEATH		3. TIME OF DEATH	_		
					IF UNDER 24 HRS.	JULY 18,	8:00 A 6. BIRTHPLACE (State or Foreign	M			
	100 12 0011		163 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	1931	Country) Texas			
Œ	9a. FACILITY NAME (If not institution, give street 12011 Whippoorwill				OR LOCATION OF DE	АТН		ITY OF DEATH			
0 C1 C1	RESIDENCE OF DECEDENT										
L DIRE	Maryland Montgo	mery		ville				10d. INSIDE CITY LIMITS? 1 YES 2 XXNO			
NERA	12011 Whippoorwill				101. ZIP CODE 109. CITIZEN OF WHAT COULD 20852 United Stat						
BY FUNERAL DIRECTOR	1 Never Married 2 Married	. WAS DECEDENT EVER IN FORCES? 1 (X) YES IF YES, GIVE WAR OR DA S.M.C. (UNA	2 NO	If yea, a	CENDENT OF HISPAN pecify Cuban, Maxican S 2 XNO Specify	IC ORIGIN? (Specify Yea n, Puerto Rican, etc.)	or No—	14. RACE — American Indian, Black, White, etc. Specify: White			
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade com	pleted)	18a. DECEDENT'S (Give kind of ville, Do NOT us	USUAL OCCUPAT work done during in the retired.)	ION ost of working	16b. KIND OF BU	SINESS/INDU				
MPLI	Elementary/Secondary (0-12)	ollege (1-4 or 5 +)	Case Oi			C. I.	Α				
	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)										
) BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	Marie	Meharg Noute Number, City or Tow	n, State, Zip	Code)	_		
2	Ransom Ratcliff			e as 10							
	20a. METHOD OF DISPOSITION 1	C	PLACE AND DATE OF PLACE AND DATE OF PLACE AND DATE OF PLACE AND DESCRIPTION OF PLACE AND DESCRIP	PEDISPOSITION (A ther place) Crema	ame of tory			City or Town, Stata le, Maryland			
	21. SIGNATURE OF FUNERAL SERVICE LICENS LICENSES	J. Ra	PP	Rapp 933 G	ist Avenu	ervices, f e. Silver	o. A. Sprir	na. MD 20910			
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reapiratory erreat, ahock, or heart failure. List only one cause on each line. Approximate Interval Between										
ľ	disesse or condition resulting in desth) a. Alzheimen's Disease.										
	a	DUE TO (OR AS A	CONSEQUENCE OF	7:				5 years	-		
CATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS A	CONSEQUENCE OF						\dashv		
	cause. Enter UNDERLYING CAUSE (Disease or Injury										
CERTIF	thet initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	ን:							
	PART II. Other algnificant conditions co	ontributing to death be	ut not resulting i	n the underlyir	g csuse given in i	Part I. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS	s		
PHYSICIAN: MEDICAL						PERFOR		AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
ME	DID TOBACCO USE CONTRIB	LITE TO CALISE OF	F DE ATU VE		1			1 TES 2 M NO			
NAN	25. WAS CASE REFERRED TO MEDICAL	= 1	F DEATH TE 26. PLACE OF DEAT				_		\dashv		
YSIC	1 TES 2 XNO	OSPITAL: Inpatient 2 - ER/Ouipe	atlant 3 🗆 DOA	OTHER: 4 - Nursing Hor	ne 5 KRealdenca	□ Other (Specify)					
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJ	JRY W	JURY AT DRK?	28d. DEŞCRIBE HOW II	NJURY OCCL	URED			
2 Accident Investigation " 1 YES 2 NO							and Number o	or Rural Route Number,	\dashv		
ETE	4 Homicide detarmined					City or Town, State)					
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN 2 MEDICAL EXAMINER: O	To the beat of my knowle	edge, death occurre	d at the lime, data	and place, and due t	to the cause(s) and man	ner as stated	d. cause(a) and mannar as stated.			
8	296 AGNATURE AND TITLE OF CERTIFIER			-,у ориноп, (29c. LICENSE NUM				_		
0 B	DZ2 iF 9										

CAUSE OF DEATH (ITEM 27) (Type, Print) 7, M. D.

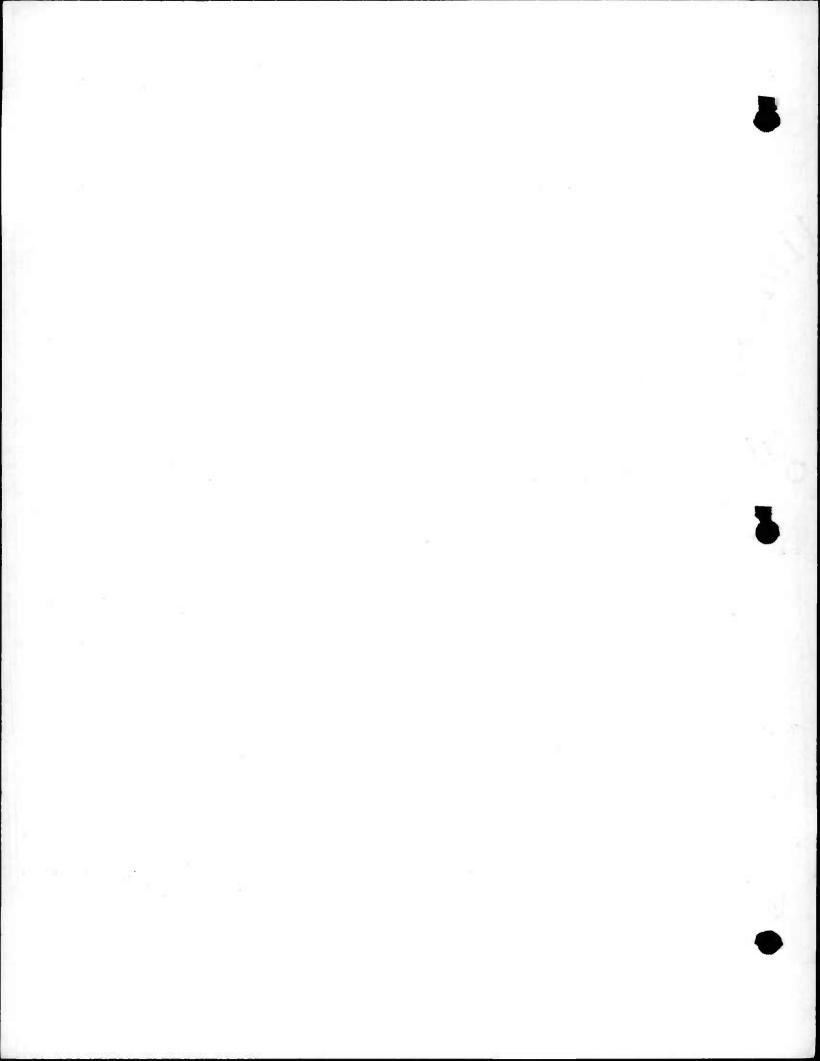
32. REGISTRAR'S SIGNATURE

8700 Georgia Avenue, #400 Silver Spring, MD 20910

Ruth Kevess-Cohen,
31. DATE FILED (Month, Day, Year)

32.

JUL 19 1995 Davidson Rendall



DIVISION OF VITAL RECORDS, P.O. BOX 68760

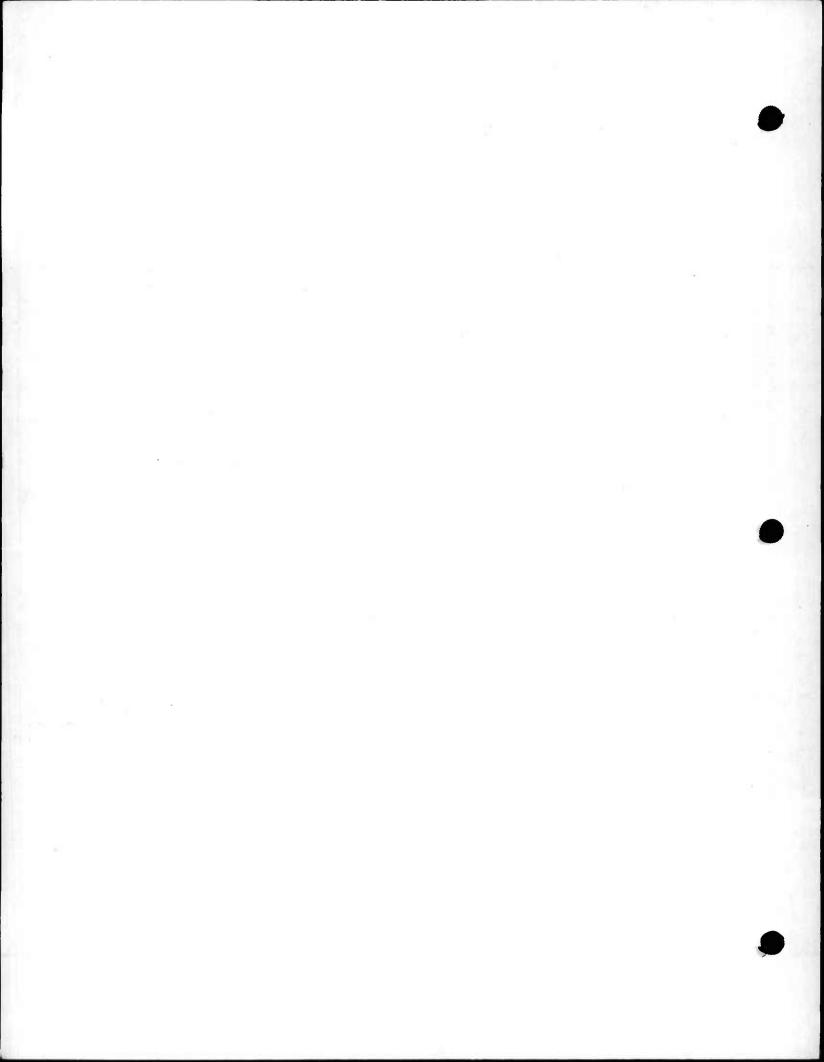
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ITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending	RAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
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R	DIR	NOUF	
A	AL	72	
	CC.		

31. DATE FILED (Month, Day, Year)

JUL 18 1995

32 REGISTRAR'S SIGNATURS
Julia Davidson Randall

									9	5 2	23427	
	1 - STATE REGISTRAR	STATE OF MAI	RYLAND /	DEPAF	RTMENT O	OF I	ALTH AND I	MENTAL HYGII				
	1. DECEDENT'S NAME (First, Middle, Last)				TORTE	<u> </u>	DEATH	2. DATE OF DEATH			3. TIME OF DEATH	
	GORDON LINCOL	LN RICHARI	CON					JULY 13,	DAY TOOS	YEAR		
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last	By Earthy orkey, ch	I se connen a su	T			1993		8:41 P M	
		1 1 M 2 □ F		YRS.	MONTHS D	_	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		Country	PLACE (State or Foreign	
	024.16.4188		72	THS.				JULY 27,	1922	MASS	ACHUSETTS	
_	9a. FACILITY NAME (If not institution, give st				9b. CITY, TO	OWN OR	LOCATION OF DE	ATH	9c. CO	UNTY OF DE	EATH	
5	SUBURBAN HOSPITAL				BETH	HESI	DA		MOI	NTGOM	ERY	
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	,		100 007	Y, TOWN OR L							
2						LOCATIO)N				10d. INSIDE CITY LIMITS?	
		GOMERY		BEI	HESDA					1X YES 2 NO		
	10a. STREET AND NUMBER					10f. 2	ZIP CODE		10g. CI	TIZEN OF W	HAT COUNTRY?	
	6813 BUTTERMERE	LANE				20	0817		U.	.S.A.		
	11. MARITAL STATUS	12. WAS DECEDENT EN			13. WAS	DECE	NDENT OF HISPAN	IIC ORIGIN? (Specify	Yes or No-	14. RACE	- American Indian,	
	1 Never Married 2 Married	FORCES? 1 XX	OR DATES	,	1 D	YES 2	NO Specify	n, Puerto Ricen, etc.)			, White, atc.	
	3 Wildowed 4 Divorced	WWII & KO	REAN								^{y:} WHITE	
	15. DECEDENT'S EDUC (Specify only highest grade		16a. DEC	ECENT'S	USUAL OCCU	PATION	of working	18b. KINO OF I	BUSINESS/IN	NDUSTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	III e. L	DO NOT U	se retired.)							
	+-							SURANCE EXECUTIVE INSURANCE				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAI	ME (First, Middle, Maid	len Sumeme)			
	KENNETH				- 1		S BATES	,				
1	19e. INFORMANT'S NAME (Type/Print)	19b.	MAILING	ADDRESS (St	tract and		Toute Number, City or 1	Tours Chats 7	Zin Code)			
2	MARY RICHARDSON						RE LANE	BETHESDA			017	
	20a. METHOO QE DISPOSITION					-						
	1 Duriel 2 A Cremetion 3 Remo	oval from State	206. PLACE AN cermetery, crem MT • C(etory or o	ther place	N (Name	e ol	7/17		- City or Tow		
	4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	Super C	Mr. CC	JMFU				ALI	EXAND	RIA, V	VA.	
-	21. SIGNATURE OF PUNISHAL SERVICE LICE	ENSEE	-)					JOSEPH				
	> \(\alpha \)	1. Teles			513	30 W	VI AVE N	W WASHING	GTON I	OC 200	016	
	23. PART i. Enter the diseases, or c	omplications that ca	used the dea	th. Do r	ot anter the	mode	of dylan suct	a se cerdier or re-	piraton, a	ree et	Approximate	
	anock, or neart fellure. L	List only one cause	on each line.				o or aying, abou	rea cardioo or rea	spiratory a	rivat,	interval Batween	
	IMMEDIATE CAUSE (Finel disease or condition	ECODI	TACE	T CARO		254				Onset and Death		
	resulting in deeth)		ESOPHAGEL CARCINOMA								18 months	
1		DUE TO (OR	DUE TO (OR AS A CONSEQUENCE OF):									
5	Sequentially list conditions,											
	if any, leeding to immediate											
3	CAUSE (Disease or injury											
EKIIFICALION	that initiated events	OUE TO (OR	AS A CONSECU	ENCE O	F):							
5	reaulting in deeth) LAST											
	PART II. Other aignificant conditions	contributing to dee	th but not rea	nulting	in the under	dylna (cettee alven in l	Domi 240 ume	AN AUTOPSY	Lan	WERE AUTOPSY FINDINGS	
FUCA						·, ····g ·	ocase given in		ORMED?	7.0	AVAILABLE PRIOR TO	
5								1 _ YES	2 X NO		COMPLETION DF CAUSE OF DEATH?	
Ε	· ———————							_ !			1 TYES 2 NO	
ż	DID TOBACCO USE CONTR	RIBUTE TO CAUS	E OF DEAT	H YE	S 🗆 NO		UNCERTAIN	1 🗆				
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOGBITAL	26. PLACE	OF OEAT	TH (Check only	one)						
7	1 TES 2 X NO	HOSPITAL:	Outpatient 3	DOA	OTHER:	Home	5 Residence	8 Other (Specify)				
	27. MANNER OF DEATH	28a. DATE OF INJU	JRY	28b. TIM	E OF 28c	. INJUR	RY AT	28d. DEŞCRIBE HOV	V INJURY O	CCURED		
	1 Netural 5 Pending	(Month, Day, Ye	oar)	INJ	M 1	WORK	(? S 2 ∏ NO					
5	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF IN.	JURY — At hom	e, ferm, s	street, factory.	office		28f. LOCATION (Street	at and Numbe	or or Russi Dr	Tuda Mumbae	
3	4 Homicide 8 Could not be	building, etc.	(Specify)			3.5.44		City or Town, Sta		ii or norei Mo	June Harrison,	
	29a. CERTIFIER			_								
COMPL	(Check only											
5	One) 2 MEDICAL EXAMINER	t: On the back of examin	nstion and/or inv	restigatio	n, in my opinio	on, deat	th occured at the i	time, data and placa,	and dua to t	the cause(s)	and manner as stated.	
ן נ	29b. SIGNATURE AND TITLE OF CERTIFIED	•				2	9c. LICENSE NUM	BER	29d. DA	TE SIGNED /	(Month, Day, Year)	
9	sery m to	n~ n				- 1	D04541				4, 1995	
2	30. NAME AND AGORESS OF PERSON WHO	COMPLETED CAUSE OF	F OEATH (ITEM	27) (Tvp=	Print)				1. 0	, 1	., .,,	
	GARY M. ROGGIN, M.					THE	SDA, MD	. 20817				
- 4								- 2001/				



YEAR

3. TIME OF DEATH

REG. NO

2. DATE OF DEATH

FOR STATE REGISTRAR

1. OECEDENT'S NAME (First, Middle, Last

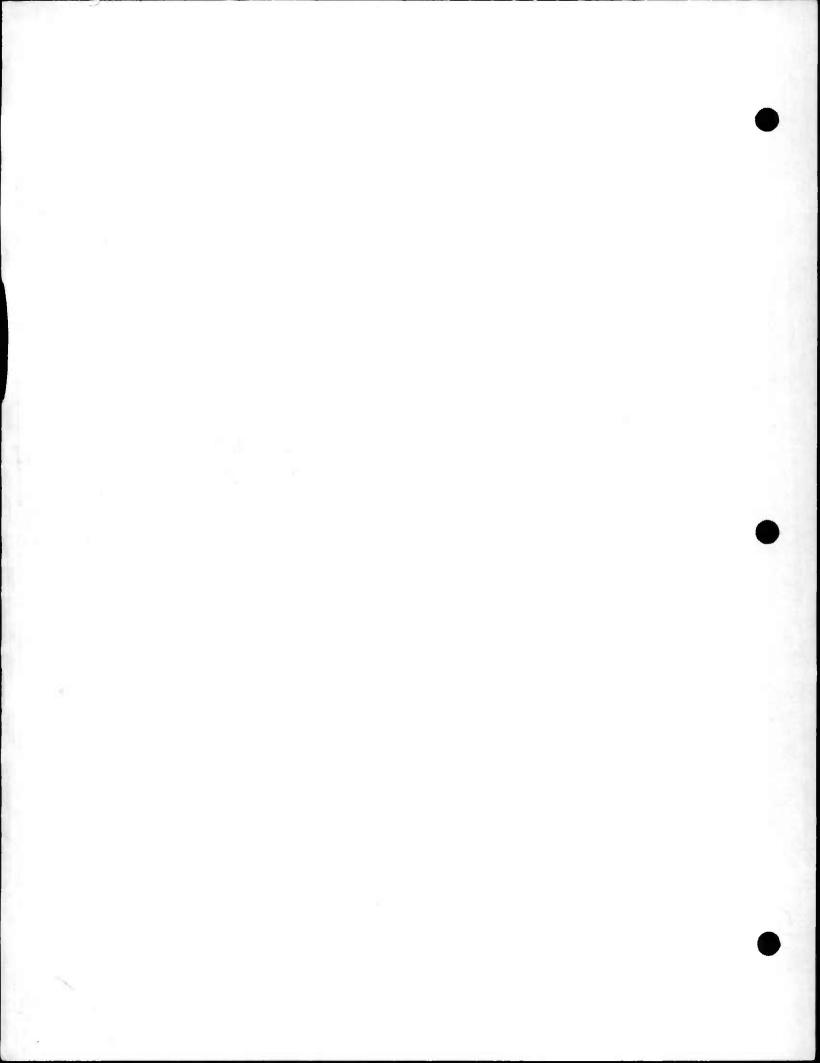
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DIVISION OF VITAL RECORDS, P.O. BOX 68760	-
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Rosenberg

a. AGE (In yrs. last birthday) 7. DATE OF BIRTH <u>Barbara Nena</u> 1005 .15 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF UNDER 24 HRS A BIRTHPLACE (State or Foreign 079-32-0471 1 M 2 K F 53 YRS. Oct. 25,1941 New York page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR 13820 Flint Rock Rd Rockville Montgomery 10e. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION Md. Montgomery Rockville 1 YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13820 Flint Rock Rd. 20853 USA cors are ceath. Page 6 may be retained by the hospital or attending physician, 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indiani, Black, White, atc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 ☐ YES 2 🌠 NO Specify: FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 M Married Specify: White В 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done its. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Analyst Government. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Lillie Rothbaum BE Harry Bordofsky 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Arnold Rosenberg Rockville, Md. 20853 13820 pe Flint Rock Rd 20a METHOD OF DISPOSITION
1 IS Burtal 2 Cremation 3 R4 20b. PLACE AND DATE OF DISPOSITION (Name of PATE 20c. LOCATION - City or Town, State must director, etory or other place 7/14 Judean Memorial Gardens Olney, Md examiner 21. SIGNATURE OF FUNERAL SERVICE ACENSE 22. NAME AND ADORESS OF FACILITY funeral Edward sagel Funeral Direction been signed by the attending physician and completely filled in by the st. of Health and Mental Hygiene prior to burial, cremation, or removal. 1091 Rockville Pike Rockville, Md 20852 medical 23. PART I. Enter the diseases or complicatione that caused the daeth. Do not anter tha mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart feilure. Liet only one ceuse on each line Interval Between Onaet and Death IMMEDIATE CAUSE (Final the ARCINOMA OF THE LEFT BREAKT disease or condition resulting in death) TASTATIC YRG event, executed within DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING death certificate be CAUSE (Diseese or injury other 1 DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. the PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? that shows any 1 YES 2 NO requires 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO Dept. UNCERTAIN [SW. 23 has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) this certificate h ltem mean HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: " 1 TES 2 NO Inpetient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 Residence 8 - Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT marked, 28d. DESCRIBE HOW INJURY OCCURED Natural 2 Accident BY 1 YES 2 NO death 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 COMPLETED 8 Could not be DIRECTOR: after 4 Homicide 28 hours ? Hem 29a. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL TO THE FUNERAL DE FIED WITHIN 72 IN IMPORTANT: If II HOSPITAL 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF BE 29¢ LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 5 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 7 MEDICAL 32. REGISTRAR'S SIGNATURE Davidson Randall 7 1995 JUL 1 DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



600

Approximate

Interval Between Onset and Death

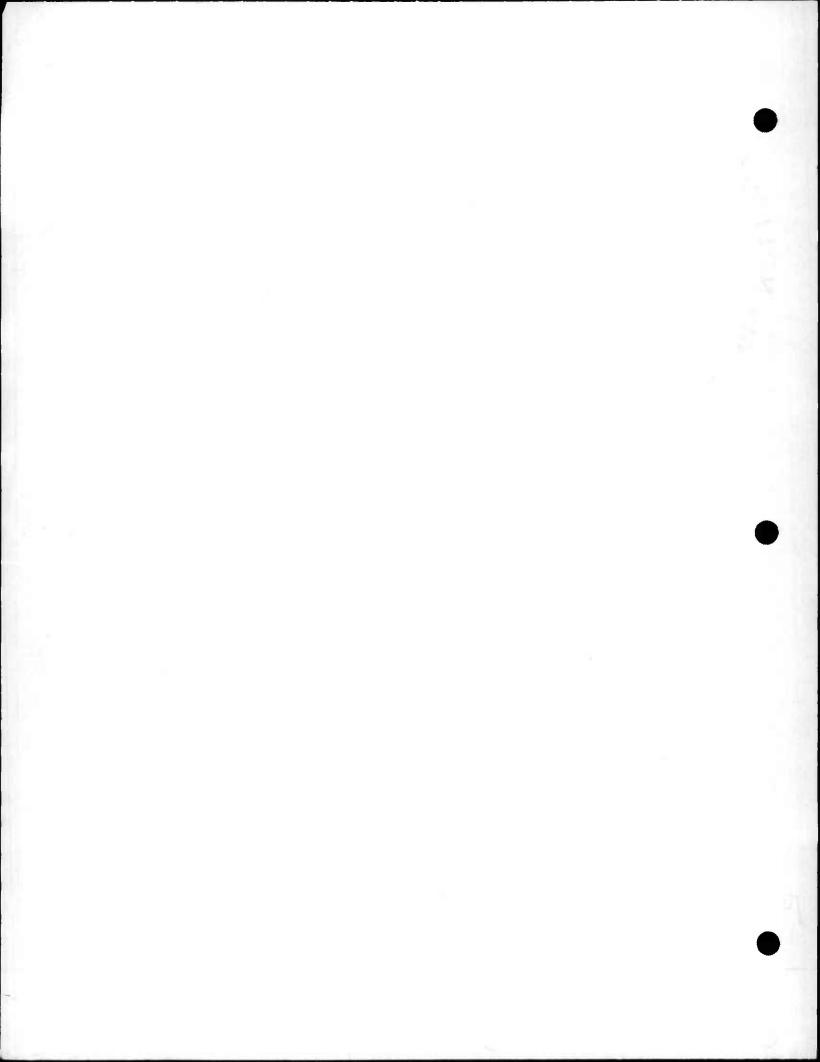
FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

2. DATE OF DEATH 495 MAAI EDWART SCHOLTZ JUL 4. SOCIAL SECURITY NUMBER 5. SEY IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 1 🛛 M 2 🗌 F 505-18-7411 7.5 July 14, Nebraska Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Holy Cross Hospital Silver Spring Montgomery RESIDENCE OF DECEDENT 10a. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 YES 2 NO the funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 10513 Brunswick Avenue 20902 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No-It yes, specify Cuban, Mexican, Puarto Rican, etc.) **BALTIMORE, MARYLAND 21215-0020** 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 X Married Specify: White BY 1 YES 2 NO Specify 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Attorney Federal Government 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) at Charles E. Scholtz Marie E. Tharp 盟 notified 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 10513 Brunswick Ave., Silver Spring, MD Virginia M. Scholtz 20902 9 20a. METHOD OF DISPOSITION
1 ☐ Burlal 2 (ACremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Metropolitan Crematory 7/18/95 4 Donation 5 Other (Specify) Alexandria, VA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W., Sil.Spr.MD 20901 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, been signed by the attending physician and completely filled in by it. of Health and Mental Hygiene prior to burial, cremation, or remo shock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Final Canay the the Gastric disease or condition resulting in death) event, DIVISION OF VITAL RECORDS, P.O. BOX 68769 DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate death certificate be CAUSE, Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST 0 Injury, PART II. Other algnificant conditions contributing to death but not resulting in the undarlying causa given in Part I. requires that the MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 - YES 2 NO Marchan myocardial 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO MI UNCERTAIN I PHYSICIAN: has be Dept. HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one HOSPITAL: certificate t 1 YES 2 NO OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 50 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26c. INJURY AT WORK? marked, 28d. DESCRIBE HOW INJURY OCCURED this with 1 Natural
2 Acciden 5 Pending Investigation 1 YES 2 NO В After t death Accident Suicide 26s. PLACE OF INJURY — At home, farm, street, tactory, office building, stc. (Specify) 3 🗌 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 8 Could not be determined DIRECTOR: / COMPLETED 4 Homicide 28 Hem 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL
TO THE FUNERAL I
BE filed within 72 h
IMPORTANT: If II mination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and manner as stated, 29d. DATE SIGNED (Marth, Day. Year) BE 2 SS OF PERSON WHO COMPLETED CAUSE OF DEATH WEM 27 (Type Print), SILVER, MY) 2104 MRAICAL POUR A.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

DHMH-16 Rev 1/89



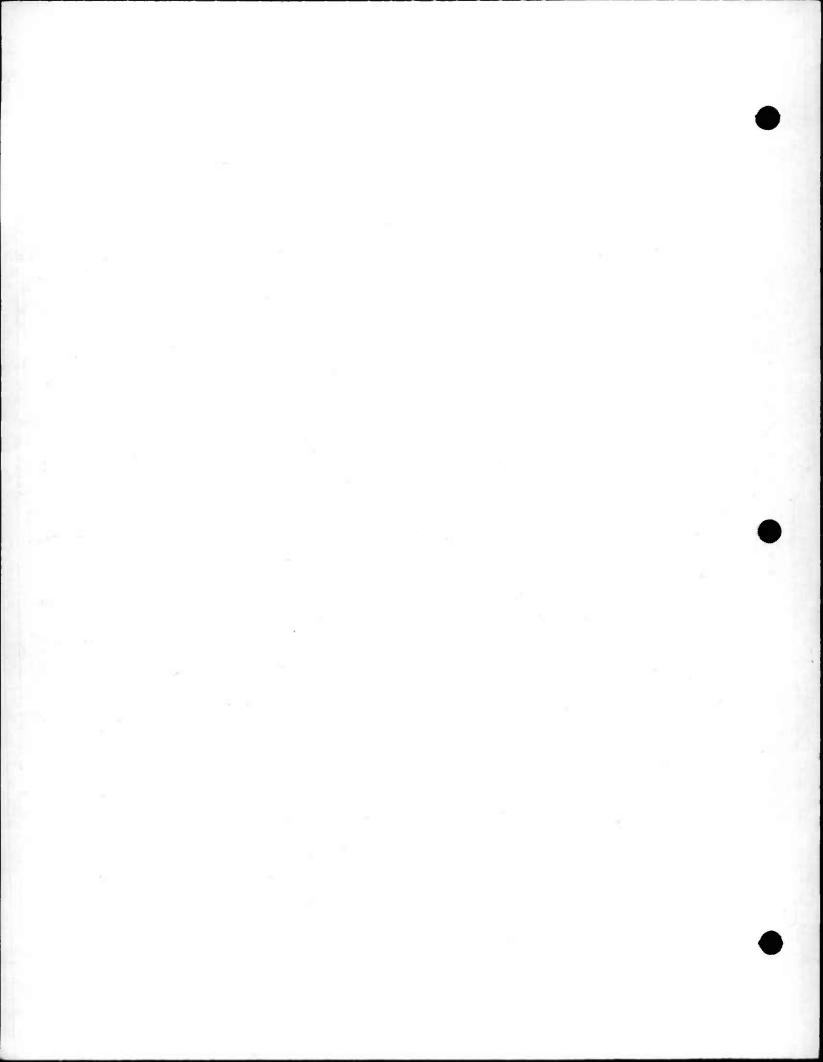
DHMH-16 Rev 1/89

REG. NO

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Lest) 2 DATE OF DEATH 3. TIME OF DEATH DAY NELLIE 1995 YEAR GRAY July 13, STEVENS 12:00 P M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Yea 8. BIRTHPLACE (State or Foreign 579-03-8623 May 29, 1904 1 M 2 X F 91 Washington.D.C. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 9009 Kensington Parkway DIRECTOR Chevy Chase Montgomery RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Montgomery Maryland Chevy Chase 1 X YES 2 NO funeral director, page 5 should be detached for use as the burial-transit permit. 10e. STREET AND NUMBER FUNERAL 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9009 Kensington Parkway 20815 United States hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerlo Rican, etc.) 11. MARITAL STATUS 14. RACE — American Indian, Black, White, aic. 1 Never Married 2 Married B 1 TES 2XXNO Specify: White 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) U.S. Government/ Treasury entary/Secondery (0-12) College (1-4 or 5+) Clerical Department 8 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Edward at Newton Nellie Gray Jett BE notified a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Elizabeth McWhorter 5615 Pickwick Rd., Centerville, Virginia 22020 pe 20s. METHOD OF DISPOSITION
1 M Burlel 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata DATE must Rock Creek Cemetery 7/17/95 Washington, D.C. FUNERAL SERVICE LICENSEE 21. SIGNATURE OF 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home, 11800 New Hamp filled in by the shire Ave., Silver Spring, Maryland 20904 medical 23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiretory arrest, shock, or heart failure. List only one cause on each line. 6 intarvai Between IMMEDIATE CAUSE (Final Onset and Death cremation, event, the disease or condition and completely fi o burial, cremation resulting in death) Cerebron cular other traumatic CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) 2 if any, landing to immedista cause. Entar UNDERLYING signed by the attending physician and Health and Mental Hygiene prior to death certificate be CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evants resulting in death) LAST injury, PART ii. Other algolificant conditions contributing to death but not resulting in the undarlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 1 YES ZYNO Shows 1 YES 2 NO been t DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO ot M UNCERTAIN \square has b. Dept. PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate I HOSPITAL: OR ATTENDING PHYSICIAN: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 Residence 8 - Other (Specify) 10 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) this c 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Netural
2 Accident 5 Pending BY 1 YES 2 NO After Investigation 3 Sulcide 28s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is DIRECTOR: / COMPLETED a Could not be 4 Homicide HOSPITAL OR AT FUNERAL DIRECT WITHIN 72 hours a 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 14/95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARTIN SHARGEL 2 ICE MSINLTON 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 1995 Navelen

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



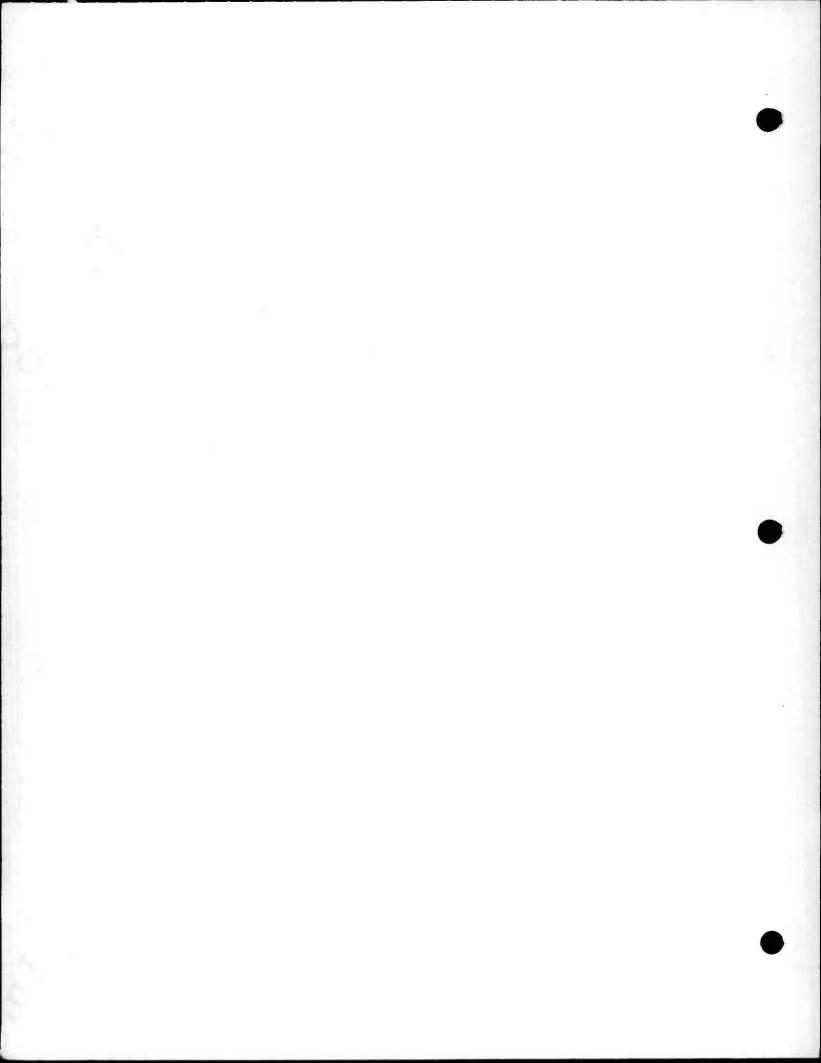
020 physician. burial-transit permit. Pages 1, 2, 3 should	FUNERAL DIRECTO	1. DECEDENT'S NAME (First, A. SOCIAL SECURITY NUMB 577-50-6588 9a. FACILITY NAME (If not in HOLY Cross RESIDENCE OF DEC 10a. STATE Md. 10a. STREET AND NUMBER 5015 Batte 11. MARITAL STATUS 1 Never Married 2	stitution, give str S Hospi S Hospi BEENT 10b. COUNTY Monto	5. SEX 1 M 2 X F eet and number) Ltal COMERY 12. WAS DECEDEN FORCES? 1	92 705 T EVER IN	In yrs. lest	YRS. 10c. CITY B	9b. CITY, TO Silv y, TOWN OR I etheso	Ver Locat da 10f 2	Spr ION ZIP CODE 20814	MIN. ON OF DE	MONT JULY 7. DATE (MONT AUG EATH	of BIRTH	1 1 Yes
MARYLAND 21215-00 retained by the hospital or attending p 5 should be detached for use as the b notified at once.	COMPLETED	3 Widowed 4 Divo	EDENT'S EDUC. highest grade co-12)	IF YES, GIVE W ATION ompleted) College (1-4 or 5+		16a, DEC (Glv life.		USUAL OCCL rork done duri e retired.)	JPATIO	st of working	ng HER'S NA	ME (First,	KIND OF I	Sa.
ALTIMORE, death. Page 6 may be funeral director, page		19a. INFORMANT'S NAME (7) Ellen Zwe: 20a. METHOD OF DISPOSITI 1 Donetton 6 Other 21. SEDNATURE OF FUNERAL	/pe/Print) LCI ON n 3 □ Ramon (Specify)	-	20b cent	PLACEA	1122	Ec	dso on (Nei cew me an dwa	on Av	or Rural I re. K neter ss of FA age1	Censi DAT TY 7/ CILITY Fun	ngton	n, Loca D:
P.O. BOX 68760 th certificate be executed within 24 hours afti- ending physician and completely filled in by 1 Hygiene prior to burial, cremation, or remo or other traumatic event, the medica	3	IMMEDIATE CAUSE (Fin disease or condition resulting in death) Sequentisity list condition from the cause. Enter UNDERLY!! CAUSE (Disease or Injuint that initiated events resulting in death) LAST	b. d. b. d. d. d. d. d. d. d.	DUE TO	(OR AS A	CONSEOL	CONCE OF	ot enter the	30	de of dyi	ng, suci	h es card		
L RECO law requires the as been signed bept, of Health 23 shows an AN: MEDIA		DID TOBACCO US 25. WAS CASE REFERRED TO EXAMINER?	SE CONTRI	BUTE TO CAL	USE O	F DEAT	H YE	S NC	one)	UNC	ERTAIN	- 1	24a. WAS PERF	ORM
SION TENDING I TENDING I Terr death Terr death Terr death Terr death		2 Accident 3 Suicide 8 0	Pending investigation Could not be latermined	28a. DATE OF (Month, Da 28a. PLACE Of building, a	INJURY ny, Year) F INJURY ntc. (Speci	— At hom	26b. TIME INJU	M 1	office	DRY AT RK? ES 2] NO	26d. DES	ATION (Street or Town, Sta	et and
DIVI TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT TO HE FINE AT TO BE GOMPLET TO BE COMPLET		29b. SIGNATURE AND TITLE	OF CENTIFIER	AN: To the best of ax. On the basis of ax.	MO	and/or In	veatigation	n, in my opini			ed at the	time, data	and place,	and
P		31. DATE FILED (Month, Day,) JUL 17		32. REGISTRAF	er's signa	Revla	Ц	· · · · ·	a	HE	ATE	Syl	M	0

CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

95 23431 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. E OF DEATH 3. TIME OF DEATH y 14, 1995 1:35 re of BIRTH onth, Day, Year) 25, 6. BIRTHPLACE (State or Foreign Country)
Germany 1902 9c. COUNTY OF DEATH Montgomery 10d. INSIDE CITY LIMITS? 1 X YES 2 | NO tog. CITIZEN OF WHAT COUNTRY? USA GIN? (Specify Yes or No-o Rican, etc.) 14. RACE — American Indian, Black, White, atc. Specify: White 6b. KIND OF BUSINESS/INDUSTRY Sales Middle, Maiden Sumame) ulhoefer mber, City or Town, State, Zip Code) ington, Md. 20895 20c. LOCATION — City or Town, State Washington, D.C. neral Direction Pike Rockville, Md. 20852 rdiec or respiratory arrest, Approximata Interval Between Onset and Death vodele 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 (NO 1 - YES 2 NO er (Specify) ESCRIBE HOW INJURY OCCURED CATION (Street and Number or Rural Route Number, y or Town, State) use(a) and manner as stated. a and place, and due to the cause(s) and manner as stated. 29d. DATE SIGNED (Month, Day, Year)

2090



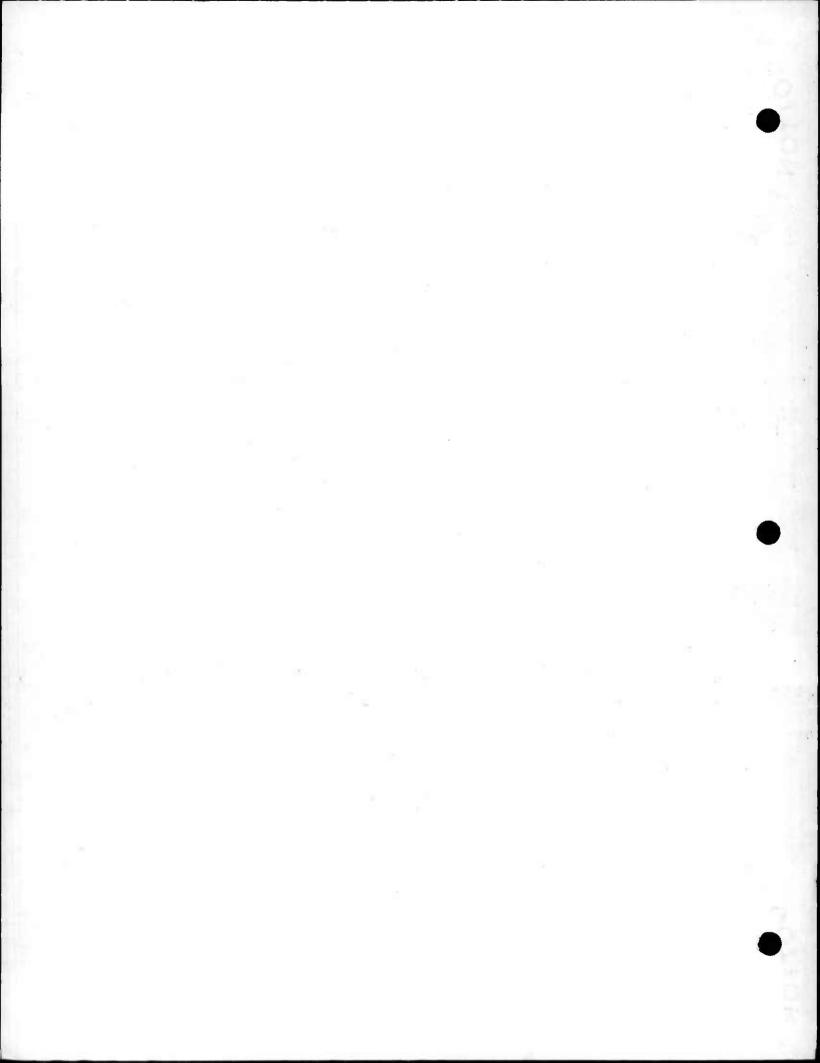
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the Hospital to a standard by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART	MENT OF H	EALTH AND I	MENTAL HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last					2. DATE OF DEATH		3. TIME OF DEATH		
	A FRANCES	SCHLAG				JULY 12		8:45 pm		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign		
	213-42-7105	1 M 2 F	74 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) May 6, 192	Coun	m) irginia		
	9a. FACILITY NAME (If not institution, give	street and number)		9b. CITY, TOWN O	R LOCATION OF DE		9c. COUNTY OF			
DIRECTOR	Washington Adven	tist Hospital		Takom	a Park		Montgomery			
1 12	10a. STATE 10b. COUN	ry	10c. CITY,	TOWN OR LOCATE	ION			10d. INSIDE CITY LIMITS?		
		ce Georges		Landov	er		1 X YES 2			
I ₹	10e. STREET AND NUMBER			10f.	ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
"	1502 Brightseat	Road #202			20785		U.S.A	١.		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DECE	ENDENT OF NISPAN	IIC ORIGIN? (Specify Years, Puerto Rican, atc.)	or No- 14. RAC	E — American Indian, ck, White, etc.		
ВУ	1 Never Married 2 X Married 3 Widowed 4 Divorced	ri, Puerto Hicari, atc.)	Spec							
ED		 					Whit	:e		
	15. DECEDENT'S ED (Specify only highest grad	JCATION le completed)	(Give kind of wo	ork done during mos	N st of working	18b. KIND OF BUS	INESS/INDUSTRY			
1 5	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use	1111						
COMPLET	17. FATHER'S NAME (First, Middle, Last)		Homemal	cer		Own H	**			
8						ME (First, Middle, Maiden :	,			
8	William Henry Ha	rrison Meadow				rances Bre				
ဍ		G.	ľ			Route Number, City or Town				
	John C. Schlag,					202 Landov				
	1 Burlet 2 Cremation 3 Ret	noval from State Cent	PLACEAND DATE OF DETERMINE OF D	er place)			CATION — City or To	12.00		
	21. SIGNATURE OF FUNERAL SERVICE L		edar Hill		TY //I		land, Mar	yland		
	D (1410/00 1.)					lins Funer	al Home,	Inc.		
	MONULO	Ti Lole		500 Un	iversity	Blvd.,W.	Sil.Spr.	,MD 20901		
	23. PART I. Enter the diseases, or	complications that caused. List only one ceuse on e	the death. Do no	ot anter the mod	de of dying, such	n as cardiac or respir	ratory arreat,	Approximata		
	IMMEDIATE CAUSE (Finsi	\						Interval Between Onset end Deeth		
	disease or condition resulting in death)	Carcus	nema i	y Len	ng wi	th met	Adrine.	,		
	disease or condition resulting in death) s. Carcinema y Leng with metastaris DUE TO (OR AS A CONSEQUENCE OF)									
Z	Sequentially list conditions,									
IEI	If eny, leeding to immediate	DUE TO (OR AS A	CONSEQUENCE OF)	:						
CERTIFICATION	CAUSE (Disease or Injury	C	CONSEQUENCE OF							
Ē	that initiated events resulting in death) LAST	DUE TO (ON AS A	CONSEQUENCE OF	•				1		
		d								
CAL	PART II. Other significant condition			the underlying	cause given in	Part I. 24s. WAS AN		. WERE AUTOPSY FINDINGS		
	H	rombobh	lebrih	i (.	lea)	PERFOR	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
一点						_ ''' '''	No.	OF DEATH?		
=	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	Z NO 🗆	UNCERTAIN	ī		1 123 2 NO		
PHYSICIAN: MEDI	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEATN	_	OTTOEKI, III					
Sic	EXAMINER? 1 YES 2 NO	HOSPITAL:		OTHER:	5 Backlance	6 Other (Specify)				
Ŧ	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	OF 28c. INJU	PRY AT	28d. DESCRIBE HOW IN	IJURY OCCURED			
	1 Natural 5 Pending Investigation	(Month, Day, Year)	11/7/5	RY WOR	RK? ES 2 NO			- 1		
BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY	— At home farm, str	reet, factory, office		281. LOCATION (Street at	nd Number or Rural	Route Number.		
E	4 Homicide determined	building, atc. (Spec	"VA			City or Town, State)		11-2-11-2		
COMPLETED	29a, CERTIFIER	SICIAN: To the heat of my beau.	lades death seemed							
Σ		SICIAN: To the best of my knowl IER: On the basis of examination								
	296. SIGNATURE AND TITLE OF CERTIFIE	121		y opinion, de						
出	296. SIGNATURE AND TITLE OF CERTIFIE	TAR			29c. LICENSE NUM	BER	29d. DATE SIGNED	(Month, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	ATH (ITEM 27 CT	700	0170	/6	- (1)	01)		
	(P1. 12 TT 11 P	CIDTA	Z/-	2 0		<2 m	1-000	0111		
	31. DATE FILED (Month, Day, Year)	20, REGISTRARIS SIGN	ATURE 250) (SUA	DE I'U	, cal	rouce		
	31. DATE FILED (Month, Day, Year) JUL 17 1995	Julia diwelson	Rendall		,		p	Mee Of Earl Z		



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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the flow is after death. Page 6 may be retained by the historian physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC	MENT OF H	EALTH AND M	ENTAL HYGIENE REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY	Y YEAR	3. TIME OF DEATH				
1			ICHER			JULY 19		7:40 PM		
	4. SOCIAL SECURITY NUMBER	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State or Foreign					
	137-22-8529		5 YRS.	ONTHS DAYS		JULY 20, 1		NEW JERSEY		
œ	90. FACILITY NAME (If not institution, give so 7706 FONTAINE S.		9		R LOCATION OF DEAT	гн	9c. COUNTY OF			
DIRECTOR	7706 FONTAINE ST	r.		POTON	4AC	MONTGOMERY				
)Ä	10s. STATE 10b. COUNTY		10c. CITY, 1	TOWN OR LOCATI	TION 10d. INSIDE CITY LIMITS?					
		TGOMERY		POTOM	IAC		1 X YES 2 NO			
FUNERAL	10. STREET AND NUMBER			101.	ZIP COOE		10g. CITIZEN OF	WHAT COUNTRY?		
N N	7706 FONTAIN							.S.A.		
	1 Never Married 2 Merried	FORCES? 1 YES IF YES, GIVE WAR OR DA	If yee, spe	cify Cuben, Mexican,	ORIGIN? (Specify Yes Puerto Rican, etc.)	Blee	CE — American Indian, ck, White, atc.			
B	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	(IES	1 L YES	2 NO Specify:		Spe	WHITE		
TED	15. DECEDENT'S EDUC (Specify only highest grade	ATION completed)	16s. DECEDENT'S US	UAL OCCUPATION done during mos	N t of working	16b. KIND OF BUSI	INESS/INDUSTRY			
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use n	etired.)						
W.	17. FATHER'S NAME (First, Middle, Last)	5+	RESEARC	H ANALY				CATIONS INC.		
	CHARLES J.	FROHLING	JR.	- 1	16. MOTHER'S NAME	E (First, Middle, Maiden S		7		
BE	19e. INFORMANT'S NAME (Type/Print)	2 2101222210		DRESS (Street on		LYDIA ute Number, City or Town,	DAMBRE:	5		
5	SUSAN STREI	CHER	SAME		TEM #10	no rearrison, only or nown,	, State, Zip Cooe)			
	20a. METHOD OF DISPOSITION 1 Duriel 2 Cremetion 3 Remo	20b.	PLACE AND OATE OF D	DISPOSITION (Nan	ne of	DATE 20c. LOC	ATION — City or T	own, State		
1 1	4 Donation 4 Other (Specify)	C.	HAMBERS C	REMATOR	Y	7/20 R	IVERDALI	E. MD.		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSPE	0	22. NAME AND	ADDRESS OF FACIL	JTY				
	* 91.911-CH	rambus	M00091	W. W.	CHAMBERS	CO. INC.	,SILVER	SPRING, MD.		
	23. PART i. Enter the diseases, or o shock, or hasrt failure.	omplications that saused List only one cause on ea	the death. Do not	anter the mod	a of dying, such	sa cardisc or respin	etory srreet,	Approximate Interval Between		
1	IMMEDIATE CAUSE (Final disease or condition	DEHYDOX	TION OT	-AD Whi	DOA. M	annen	Tuene	Onset and Death		
	disease or condition									
z	- Amamall cell, basic par of KOI- 18M									
E	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):			1		0 40		
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	- DKHIN	METAS	T1956	Š.			317		
CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
l iii].								
AL.	PART II. Other eignificant condition	contributing to deeth bu	it not resulting in t	ha underlying	ceuse given in Pa	ITT I. 24s. WAS AN A		. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO		
MEDIC	- Mone					_ 1 _ YES 2	NO	COMPLETION OF CAUSE OF DEATH?		
						_	`	1 _ YES 2 _ NO		
AN	DID TOBACCO USE CONTR			NO 🗆	UNCERTAIN					
PHYSICIAN	EXAMINER?	HOSPITAL:	6. PLACE OF DEATH (THER:	\/					
HYS	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outps 26e. DATE OF INJURY	26b. TIME O	Nursing Home F 28c. INJU	/	Other (Specify) 6d. DESCRIBE HOW IN.	*****			
	1 Netural 5 Pending	(Month, Day, Year)	INJURY	WOR 1 YE	K?	ed. DESCRIBE HOW IN.	JURY OCCURED			
BY	Accident Investigation 3 Suicide 6 Could not be	26s. PLACE OF INJURY	At home, farm, atres			61. LOCATION (Street an	d Number or Rural	Route Number.		
TED	4 Homicide determined	building, atc. (Special	19)			City or Town, State)				
2	290. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my knowle	rdge, death occurred a	t the time, date e	nd place, and due to	the cause(e) and menn	or as stated.			
COMPLET		R: On the basis of examination						e) end menner as stated,		
ш	190 BIGMATURE AND TITLE OF CERTIFIER	OLU DIALA	/		29c. LICENSE NUMBE	ER OLL	29d. DATE ŞIGNED	(Month, Day, Year)		
0 B	X 1. Wh 11	EUNDUY/		1	216-25	-2643	► 7/201	195		
F	30. NAME AND ADDRESS OF PERSON WHO OF HAVE 31. DATE FILED (Month One Mark)	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Prin	RIT	HECAL	1 100 0	100			
		1 .32. AEGISTRAR'S SITUA	TAREA	HOI	BUNDA	111/ /0	1814			
	JUL 21 1995 J	,32. AEGISTRAR'S SIGNA	dall			•				

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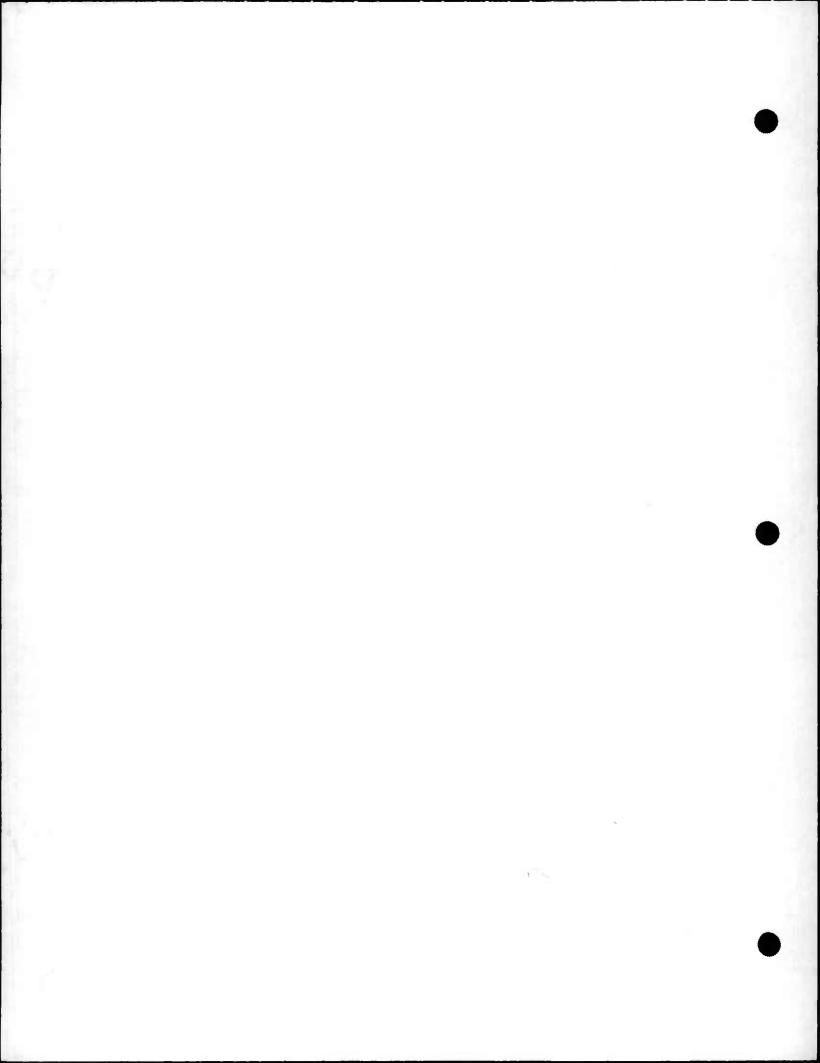
Amended #1, 7/21/95 JW Montgomery Co.

1- STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

	1. DECEDENT'S NAME (First	, Middle, Last)	-01-	- "		1	. /		2. DATE OF D			MEAR	3. TIME OF DEATH			
	JUANA	D 2.F	TRLO.	luanit	a 1	Tae S	erli		July	18	1	995	1:55 P m			
	4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. las	birthday)	IF UNDER 1 YEA		24 HRS.	7. DATE OF B	HRTH		8. BIRTH	IPLACE (State or Foreign			
	129-10-453	3	1 🗌 M 2 🔀 F	84	YRS.	MONTHS DAY	HOURS	MIN.	Aug. 5	, 19	910 New York					
	9a. FACILITY HAME (If not in	stitution, give s	street and number)			9b. CITY, TOW	b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH									
OR	Holy Cross		:al			Silver Spring Montgomery										
5	RESIDENCE OF DEC	10b. COUNT														
H	Lan and the second		LIMITS?								10d, INSIDE CITY LIMITS?					
0	Maryland		gomery	Ga	aithers							1 YES 2XXNO				
A	10e. STREET AND HUMBER		_				101. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?					
FUNERAL DIRECTOR	23604 Dixie	Ridge			20882						U	SA				
5	11. MARITAL STATUS 1 Never Married 2	Marriad	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AR	MED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea if yea, specify Cuban, Maxican, Puerto Rican, etc.)						or No—	14. RACI	E — American Indian, k, White, atc.			
В	3 X Widowed 4 Divo		WW TI		1 ☐ YES 2 ☑ NO Specify:							Spec	ify:			
<u> </u>	15 DEC	EDENT'S EDU			CEDENT: 0	USUAL OCCUPA	71011						White			
	(Specify only	y highest grade	completed)	(G/	ve kind of w Do NOT us	ork done during retired.)	most of workin	g	16b. KINI	D OF BUS	INESS/IHC	DUSTRY				
COMPLET	Elementary/Secondary (0	1-12)	College (1-4 or 5 -	•)			TT									
N	17. FATHER'S NAME (First, M	liddin Last)	1		omema	aker	48 14075	UEDIO NAS	ME (First, Middle	Hom						
	Harry Larab										Surname)					
出	19a. INFORMANT'S HAME (1			100	MAILING	ADDRESS (Stree			Cruth							
2		Serlo											m 00000			
	20a. METHOD OF DISPOSIT					Dixie FDISPOSITION		Cou	DATE							
	1 NBuriel 2 Cremation 4 Donation 5 Other		oval from State	cemetery crei	natory or of	er place) Semeter	· 37	7/	20/95							
	21. SIGHATURE OF FUHERA		CENSEE	Larks	awii (-	AND ADDRES			ROC	KVII.	re,	Ш			
- 1	1	1 000						Francis J. Collins Funeral Home, Inc.								
	Come	2 ,		4		500	Unive:	rsity	y Blvd	.W.	Sil.	Spr.	MD 20901			
	23. PART b Enter the di ahock, or he	iseasea, or o	complications the List only one cau	t caused the de	eth. Do n	ot enter the r	node of dyl	ng, auch	es cerdiec	or reapir	atory arr	reat,	Approximete			
	IMMEDIATE CAUSE (Fin		- A	a con each mile.	40								interval Between Onset and Death			
	disease or condition resulting in deeth)	→	accep	& Osp	wats	or p	ulen	ga-	-				Voller			
	DUE TO (OR AS A CONSEQUENCE OF):															
N	Sequentially list conditions, 6.															
CERTIFICATION	DUE TO (OR AS A COHSEQUENCE OF): the any, leading to immediate cause. Enter UNDERLYING															
5	CAUSE (Disesse or inju		c	(00.40.4.00)												
Ē	thet initiated events resulting in death) LAS	т .	DOE 10	(OR AS A CONSEC	UENCE OF):										
岗	-d.															
	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS															
MEDICAL	_ Urbe	rund	eco Br	caro.	des	use				PERFOR		1	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
			-						_ ' _	YES 2			OF DEATH?			
	DID TOBACCO U	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN														
Ž	25. WAS CASE REFERRED TO					1 (Check only or										
PHYSICIAN:	EXAMINER?		HOSPITAL:	ER/Outpetlant 3	□ DOA	OTHER: 4 Hursing H	ome 5 Re	aldence f	Other /Sno	ocific)						
₹I	27, MANNER OF DEATH		28a. DATE OF	INJURY	28b. TIME	OF 28c. I	NJURY AT	_	26d. DESCRIB		JURY OCC	CURED				
BY		Pending Investigation	(Month, D	ay, rear)	INJU		WORK? YES 2	NO								
	2 Culoido	Could not be	28a. PLACE O	F INJURY — At hor	ne, fêrm, at	reet, factory, of	fica		28f. LOCATION	(Street ar	nd Number	or Rural F	loute Number,			
ш		detarpfined	bullaing,	atc. (Specify)					City or Tow	vn, State)						
۳	29a. CERTIFIER	IFYING PHYSI	CIAN: To the best of	my knowledge des	th occurre	d at the time of	to and place		- 45							
\$													and magner as stated			
29a. CERTIFIER (Check only one) 2 MEDICAL EXAMIHER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and menner at the time, data and place, and due to the cause(s) and the time, data and place, and due to the cause(s) and the time, data and place, and due to the cause(s) and the time, data and place, and due to the cause(s) and the time, data and place, and due to the cause(s) and the time, data and place, and due to the cause(s) and the time, data and place, and due to the cause(s) and the time, data and place, and due to the cause(s) and the time, data and place, and due to the cause(s) and the time, data and place, and due to the cause(s) and the time, data and place, and due to the cause(s) and the time, data and place, and due to the cause(s) and the time, data and place, and due to the cause(s) and the time, data and place, and due to the cause(s) and the time, data and the time, data and the time, data and the time,																
H	290. SIGNATURE AND TITLE	OF CENTIFIE	Loub,				29c. LICE	NSE NUM	DLL		29d. DATI	E SIGNED	(Month, Day, Year)			
2	30 HAME AND ADDRESS OF	DEDCON WITH	COMPLETED	E OF BEITH ATT	1070 (7	0.1.11	100	00	17		1/	1/8	178			
	30. HAME AND ADDRESS OF	/ ENSON WH	LENKIA		27) (Type,	erine) 2	309	508	POREF	-1EC	DR	05				
	31. DATE PILED (Month, Day,	Vaur)	- 7 77			w	HEA	100	m	0	000	28 5	_			
		395 A	ala davole	R'S SIGNATURE												
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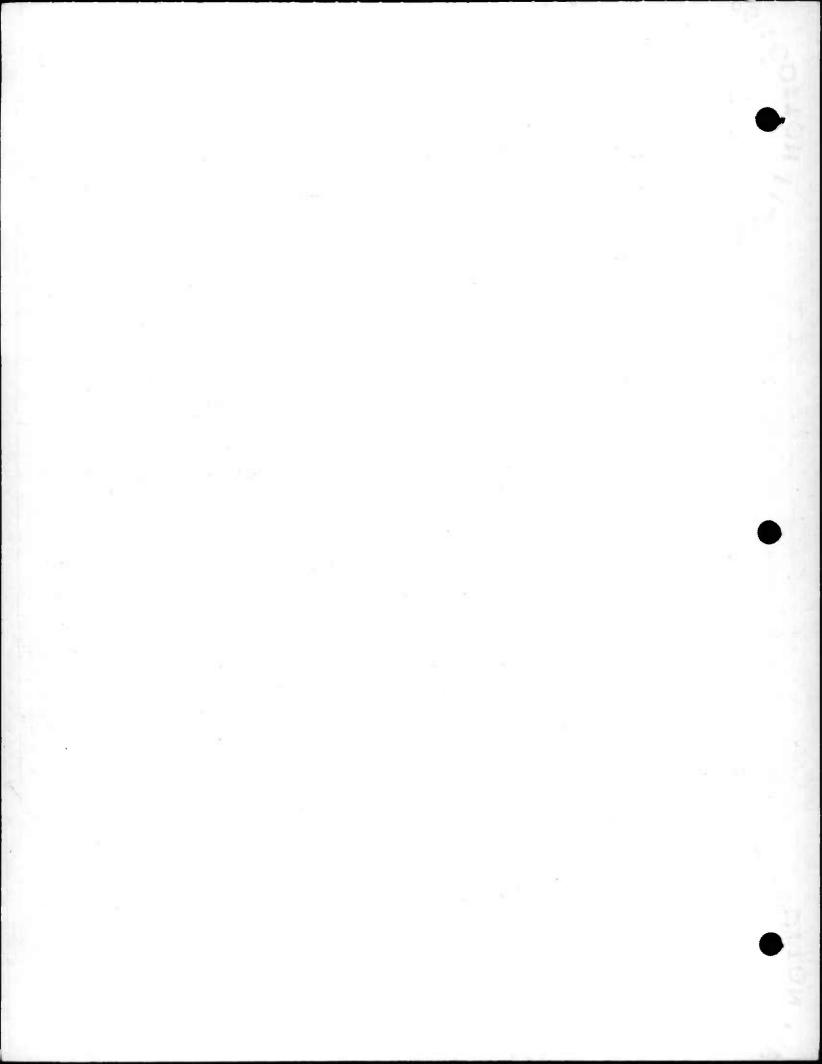


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		1. DECEDENT'S NAME (First, Middle, Last)	nalls		57	AFF	-01	8 D	2. DATE OF OEATH	43	YEAR 3. TIME OF DEATH	
	IERAL DIRECTOR	4. SOCIAL SECURITY NUMBER		E (In yrs. less		IF UNDER 1 Y	_	IF UNDER 24 HRS.	7. DATE OF BIRTH	198	73 1/33 F M	
		579-09-2277	1 🕅 M 2 🗆 F	88	YRS.			HOURS MIN.	(Month, Day, Year)	006	a. BIRTNPLACE (State or Foreign Country)	
pinous		Se. FACILITY NAME (If not institution, give s	treet and number)		- 100	9b. CITY, TO	WN OR	LOCATION OF DE	Sept.15,1		Washington, DC	
23		Shady Grove Hosp:	ital			Roc	kvi	.11e			ntgomery	
Pages 1,		10e. STATE 10b. COUNTY	1		10c. CITY	r, TOWN OR I	OCATIO	ON			10d. INSIDE CITY	
permit. Pa			ntgomery		Ga	ither	sbu	rg			LIMITS? 1 YES 2 X NO	
		8312 Frontwell C:	irclo					ZIP CODE 879			EN OF WHAT COUNTRY?	
020 physician. burlal-transit	FUNER	11. MARITAL STATUS	12. WAS DECEDENT EVER	R IN U.S. ARI	MED	13. WAS			IIC OBIGIN? (Specify Ver		USA 14. RACE — American Indian.	
5-0020 nding physic as the burial		1 Never Married 2 Married	FORCES? 1 , YE	S 2 N	2 □ NO If yes, specify Cuban, Mexican, Puerto Ricen, etc.) Black, W ATES 1 □ YES 2 ☒ NO Specify: Specify:							
215-0020 attending physician se as the burlal-tra	D BY	3 🔀 Widowed 4 🗌 Divorced	WW)	II				11.			White	
	ETED	15. DECEOENT'S EDU (Specify only highest grade		(GH	CEOENT'S I we kind of w Do NOT use	OSUAL OCCU	PATION og most	of working	16b. KIND OF BUS	SINESS/INDL	JSTRY	
	IPLE	Elementary/Secondary (0-12)	College (1-4 or 5+) 2			litor			Federal	Gove	rnment	
MARYLAND : retained by the hospital 5 should be detached it notified at once.	COMPL	17. FATNER'S NAME (First, Middle, Last)					T	16. MOTHER'S NAI	ME (First, Middle, Maiden			
_ ≥ % tal	BE (Unknown	Stafford						Heany			
MARY e retained b 5 should notified	5	19e. INFORMANT'S NAME (Type/Print)		196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8312 Frontwell Circle Gaithershurg, MD 20879								
ay be		Barbara DeFries 20a. METNOO OF DISPOSITION		8312 Frontwell Circle Gaithersburg, MD 20879 ACEANDDATE OF LOCATION - City of Town, State								
ALTIMORE death. Page 6 may e funeral director, pag it. examiner must b		1 XBuriel 2 Cremation 3 Remarks Donation 5 Other (Specify)	emetery, cren Gate	natory or out	her place) Leaver	N (Name	emeterv	7/21/95 Si	cation – c	Spring, MD		
TIM Page ral direc		21. SIGNATURE OF FUNERAL SERVICE LIC				22. NAI	AE AND	ADDRESS OF FAC	CILITY			
		> (Inchew)	J. Colo			Fra 500	nci Un	s J. Coliversity	llins Fune v Blvd.W.	ral H Sil.S	ome, Inc. pr.MD 20901	
B/ hours after d d in by the or removal, medical e		23. PART I. Enter the diseases, or o	omplications that caus	ed the da	eth. Do n							
		shock, or heart failure. IMMEDIATE CAUSE (Final		0 1							Onset and Death	
d within 24 ompletely fills cremation, the event, the		resulting in death)	Asysto	Xe.							0 1	
	_	_	DUE TO (OR AS	CA CA	UENCE OF	in bol	21	/ MY	o Curdin	Q in	farction 6Hs	
× 5 5 5 5	CATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQ	UENCE OF):	-/				DIN3	
BO cate be hysicial prior	S	cause. Enter UNDERLYING CAUSE (Disease or Injury	HYPOTO								6 Hm	
certificate ding physi tygiene pr	RTIFI	that initiated events resulting in death) LAST	A Spinati	C-	DENCE OF	uma	wi	CI		1 days		
G, P death atten ental H	SE										1 (0.00)	
를 등 을 을	DICAL	PART II. Other significant condition							Part I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
3 = 8 = 6	EDIC	Sepsis/ E	ELectrol	XIV	-1~	A DO X	- (A, N	va	1 _ YES 2	XNO	COMPLETION OF CAUSE OF DEATH?	
2000	Σ	DID TOPACCO LICE CONTE	NALITE TO CALLE		10'						1 TYES 2 NO	
law law	PHYSICIAN:	DID TOBACCO USE CONTR	CIBUTE TO CAUSE			S LI NC	-	UNCERTAIN	1 🗆			
SICIAN: The certificate h the State h	SIC	EXAMINER?	HOSPITAL:			OTHER:		5 □ Gaeldanes I	8 Other (Specify)			
OF V PHYSICIA this certif with the rked, or	놝	27. MANNER OF DEATN	28e. DATE OF INJURY (Month, Day, Year)	Y	28b. TIME	OF 286	. INJUR	TA YE	28d. DESCRIBE HOW II	NJURY OCCU	JRED	
ON O DING PHYS After this death with	BY	1 Pending 2 Accident Investigation	(Moran, Sey, rear)		INGC		_	S 2 NO				
0 0 0 0	8	3 Suicide a Could not be	28e. PLACE OF INJUR building, etc. (Sp	RY — At hon pecify)	ne, lerm, st	reet, lactory,	offica		281. LOCATION (Street e City or Town, Stete)	nd Number o	or Rural Route Number,	
DIVISI OR ATTEN OIRECTOR: bours after item 28 I	E .											
로 걸 본 보	COMPLET	(Check only	CIAN: To the best of my kno									
(Check only one) 2 MEDICAL EXAMINER: On the basic of axamination end/or investigation, in my opinion, death occurred at the time, date end place, and one) 2 MEDICAL EXAMINER: On the basic of axamination end/or investigation, in my opinion, death occurred at the time, date end place, and one) 2 MEDICAL EXAMINER: On the basic of my knowledge, death occurred at the time, date end place, and one) 2 MEDICAL EXAMINER: On the basic of my knowledge, death occurred at the time, date end place, and one) 2 MEDICAL EXAMINER: On the basic of my knowledge, death occurred at the time, date end place, and one) 2 MEDICAL EXAMINER: On the basic of my knowledge, death occurred at the time, date end place, and one) 2 MEDICAL EXAMINER: On the basic of axamination end/or investigation, in my opinion, death occurred at the time, date end place, and one) 2 MEDICAL EXAMINER: On the basic of axamination end/or investigation, in my opinion, death occurred at the time, date end place, and one) 2 MEDICAL EXAMINER: On the basic of axamination end/or investigation, in my opinion, death occurred at the time, date end place, and the place is a supplication of the basic of axamination end/or investigation, in my opinion, death occurred at the time, date end place, and the place is a supplication of the place is a s												
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If	BE		(S.K	umf	top. 1	10)	ľ	D/8/	9 B	29d. DATE	SIGNED (Month, Day, Year)	
=	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	EATH (ITEM	27) (Type,	Print)	2	0.	0:10			
0+1					(NTEM 27) Cope, Prior) #2200 Riverdale, Md. 20737							
		31. DATE FILED (Month, Day, Year) JUL 21 1995	La Diviliar la	wall								
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



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the hospital or attending physician. detached for use as the burial-transit AND 21215-0020 director, page 5 should be retained by Page 6 may be hours after death. completely filled in by the 0 cremation, with executed to burial, been signed by the attending physician it, of Health and Mental Hygiene prior to requires that the death certificate be HOSPITAL DR ATTENDING PHYSICIAN: The law has be Dept. 23 r this certificate h Item DIRECTOR: After the hours after death was 28 TO THE HOSPITAL OF THE FUNERAL D be filed within 72 ho

Pages 1, 2, 3 should

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DIRECTOR

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH MDNTH 3. TIME OF OEATH GEORGE ALBERT STEPHAN 23, 1995 July 11:30 A M 4. SOCIAL SECURITY NUMBER 8. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year)
Jan 17, DAYS HOURS 100 M 2 | F 213-24-7551 YRS 65 1930 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Carroll County General Hospital Westminster Carroll RESIDENCE OF DECEDENT 10b. COUNTY 10a. STATE 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Carrol1 Westminster 1 - YES 2 NO 10e. STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? 577 Marshall Drive 21157 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 12 YES 2 □ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specity Cuban, Maxican, Puarto Rican, atc.) 1 TYES 2 NO Specify: 3 Widowed 4 Divorced White 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig College (1-4 or 5+) Restaurant Manager 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) Albert D. Stephan Anna Belle Martin 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna M. Stephan Marshall Drive, Westminster, MD 21157 20a. METHOD OF DISPOSITION

☆ Burial 2 □ Cremation 3 □ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of 7/26 Gardens 20c. LOCATION - City or Town, Stata Evergreen 4 Donation 5 Other (Specify) Memorial Finksburg, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Myers Funeral Home 91 Willis Street, Westminster, 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart fellure. List only one ceuse Interval Between IMMEDIATE CAUSE (Finel Onset and Death disease Dr condition day resulting in death) OUE TO (OR AS A CONSEQUENCE OF) Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 10 OF DEATH? 1 | YES 2 100 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 | YES 2 | 10 Inpetiant 2 - ER/Outpetiant 3 - DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner se stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) augn

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
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1130 Backinger

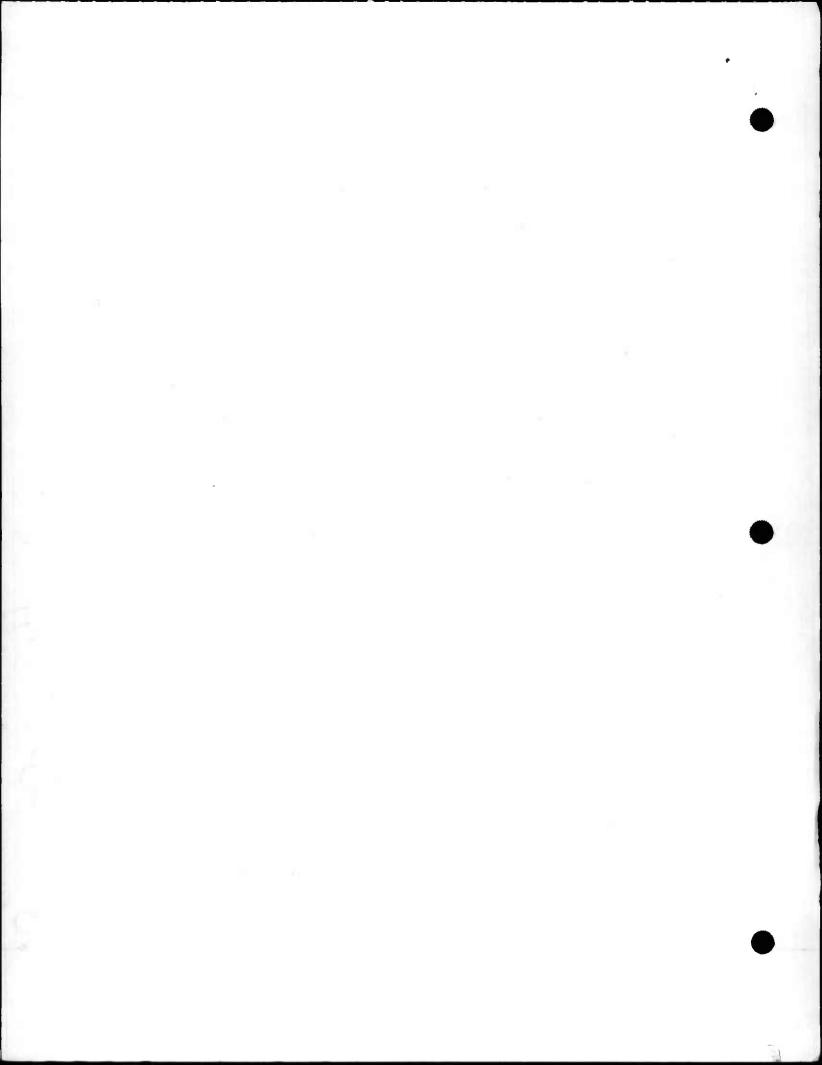
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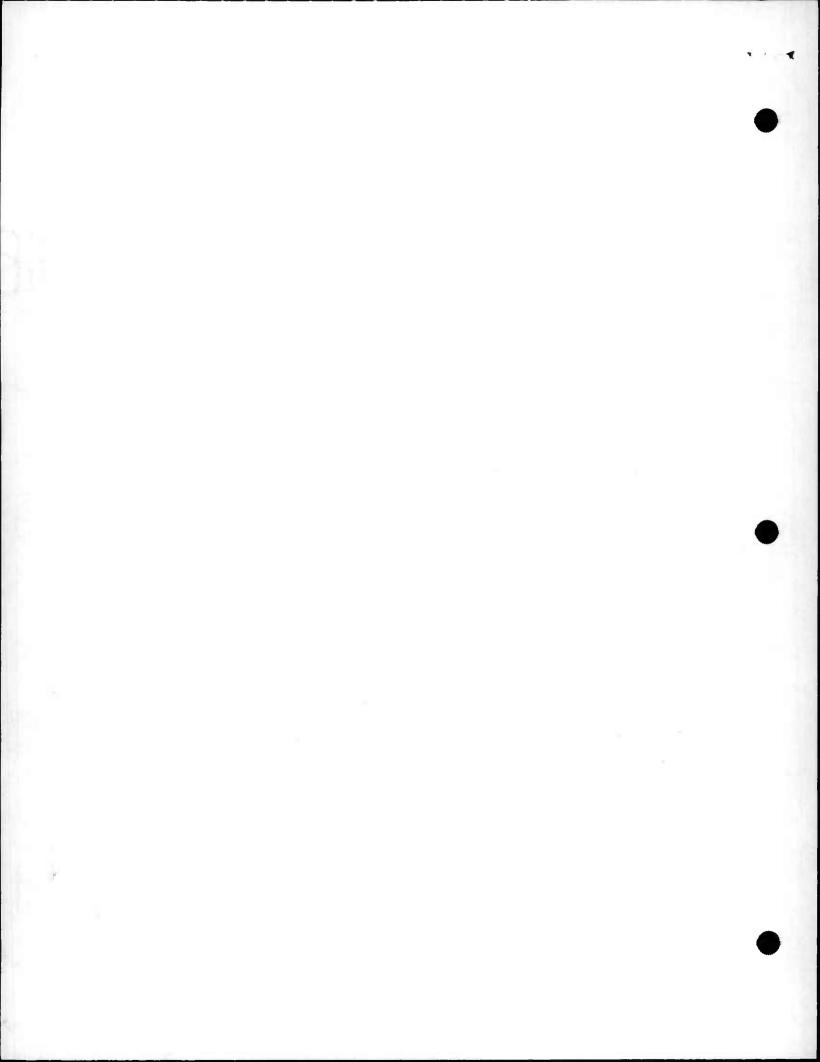
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		1 - STATE REGISTRAR	STATE OF MARYL		RTMENT OF ICATE OF		REG. NO.				
		DECEOENT'S NAME (First, Middle, Last)	JOHN IRV	ING SIE	S		JULY 21	1995	3. TIME OF DEATH 11:15 P M		
10	PLETED BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 220-03-1461	5. SEX 6. AGE (in yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS	#F UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 7/2/1923		BIRTHPLACE (State or Foreign Country) MARYLAND		
2, 3 should		9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH									
Pages 1,		10a. STATE 10b. COUNTY MARYLAND	CARROLL		TY, TOWN OR LOCA VESTMIN			10d. INSIDE CITY LIMITS2 1 YES 21 NO			
n. ansit permit.		100. STREET AND NUMBER 718 HOLIDAY LA	ANE	•	10	21157		10g. CITIZEN	OF WHAT COUNTRY?		
21215-0020 al or attending physician. for use as the burial-transit		11. MARITAL STATUS 1 Never Merried 2 X Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DO WWW.	2 NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yee, specify Cuben, Mexican, Puerto Ricen, etc.) 1 YES 2 NO Specify: WH 3						
spital or attending ned for use as the		15. DECEOENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	(Give kind of life. Do NOT u	work done during m se retired.)	ost of working		SINESS/INDUSTRY ACTURING				
MARYLAND 2 retained by the hospital 5 should be detached for notified at once.	E COMPL	17. FATHER'S NAME (First, Middle, Last) HOV	Sumame) SIMON								
. 2 8 0	TO B	190. INFORMANT'S NAME (Type/Print) EVELYN L. SIES		19b. MAILING 718	ADDRESS (Street HOLIDA	and Number or Rural Y LANE,	Route Number, City or Town WESTMINS	n, State, Zip Coo STER ,	MD. 21157		
e 6 m rector.		20b. PLACE AND OATE OF DISPOSITION DESCRIPTION State 20b. PLACE AND OATE OF DISPOSITION (Name of cemetery, crematory or other place) A Donattons Of State Other (Specify) 20b. PLACE AND OATE OF DISPOSITION (Name of cemetery, crematory or other place) KEYSVILLE UNION CEM. 7 / 24 / 9 KEYSVILLE, MD.									
SALTI r death. P ee funeral al. examin		22. NAME AND ADDRESS OF FACILITY FLETCHER FUNE 254 E.MAIN ST., WESTMINSTER,									
within 24 hours at mpletely filled in by cremation, or removed in the medical control of the medical control of the medical control of the medical control of the medical control of the medical control of the medical control of the medical control of the control		23. PART i. Enter the diseases, or c shock or heart failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	omplications that ceused let only one cause on education of the course on education of the course of	ich line.			ch es cardiac or respi	retory errest,	Approximate interval Batween Onset and Death		
. BOX 68 ificate be execute physician and c ne prior to buria	IFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events		CONSEQUENCE O							
death attendental Henral H	CERTIFI	resulting In deeth) LAST	•								
signed by Health and Ws any Ir	MEDICAL	PART II. Other significent conditions	contributing to death b	ut not regulting	in the underlyin	g cause given in	Pert I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
AL RI I law rec nas beer Dept. of		DID TOBACCO USE CONTR		F DEATH YE			ИП		1 - YES 2 - 3-40		
certification of It	PHYSICIAN:	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpetient 2 ER/Outp 28a. DATE OF INJURY	atlent 3 DOA			6 Other (Specify)	HIDV OCCUPE			
고 등 등을 등	B⊀	Natural 5 Pending Accident Investigation Suicida 6 Could not be	— At home, ferm,	M 1 □	M 1 YES 2 NO			IE HOW INJURY OCCURED			
R ATTEN RECTOR: urs after um 28 I	ETED	4 Homicide determined	building, etc. (Spec	ny)			28f, LOCATION (Street a City or Town, State)		ural Houte Number,		
보 보 다 느	COMPLE	(Check only one) 1 CERTIFYING PHYSIC ONE) 2 MEDICAL EXAMINER	IAN: To the best of my knowl						use(a) and manner as stated.		
TO THE HOSPIT TO THE FUNERA DE filed within 7	BE	296. SIGNATURE AND TITLE OF CERTIFIER V C	juely r	2		D 23	443	29d. DATE SIG	22 95		
	6	30. NAME AND AODRESS OF PERSON WHO	COMPLETED CAUSE OF OE	OST MIN	Ster 1	ned co	TR 1130	Belfin	more Blvd		

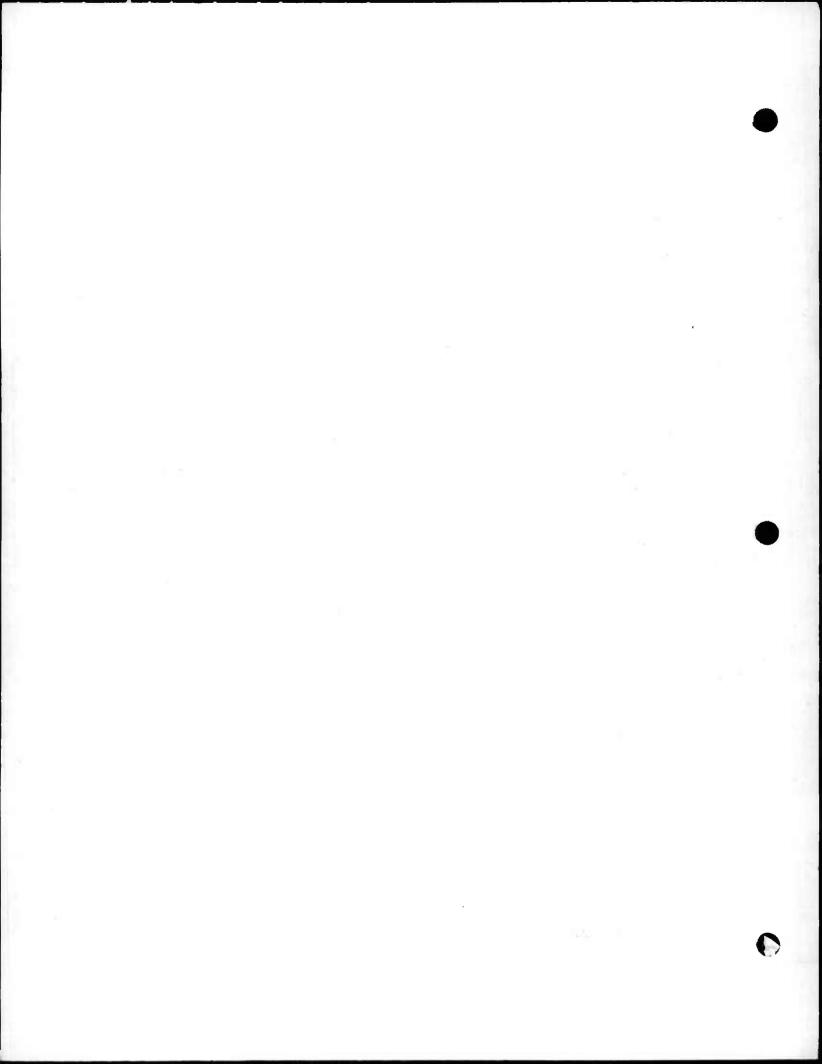


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DIVISION OF VITAL RECORDS, P.O. BOX 68760	ATTEN
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		1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF I	HEALTH AND	MENTAL HYGIEN					
		1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	MY YEAR	3. TIME OF DEATH			
		JACOB Wa	SEIB	yrs. last birthday)			JULY 2	1, 1995	6:40 PM			
9		214-16-2648	1気M2口F 7		IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Nova 10,1	921 Ma	THPLACE (State or Foreign ary)			
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Pages	DIREC	10e. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCA				10d. INSIDE CITY LIMITS?			
permit. I		Maryland A	llegany		140	Frostbu	rg	I	1 X YES 2 NO			
nsit pe	ERAL	222 East Main St	reet		"	21532			WHAT COUNTRY?			
215-0020 attending physician. use as the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO	If yes, sp	CENDENT OF HISPA	NIC ORIGIN? (Specify Yes	CE — American Indian, ck, White, atc.				
r attending use as the	8	15. DECEDENT'S EDUC (Specify only highest grade	CATION	18a. DECEDENT'S	JSUAL OCCUPATION done during me	ON .	16b. KIND OF BU	SINESS/INDUSTRY	MILLOG			
al or for t	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Inte. Do NOT use	retired.)	ost of working						
AND the hospit detached once.	COMP	17. FATHER'S NAME (First, Middle, Last)		Mach	inist	18 MOTHED'S NO	GLas	s Manufa	cturing			
क विक	w i	John	S	eib		Isab		Ra	e			
MAR retained 5 should notified	TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural	Route Number, City or Tow	vn, State, Zip Code)				
be sage		Margaret 200 METHOD OF DISPOSITION	Seib				rostburg M					
Page 6 may al director, page inext b		1 A Buriel 2 Cremation 3 Remote 4 Donation 5 Other (Specify)	ovel from State	PLACE AND DATE O				CATION — City or 1				
ALTIMOR death. Page 6 m e funeral director, i.		4 Donation 5 Other (Specify) Rocky Gap Veter ans Cemetery 7/24/95 Flintston 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Durst Funeral Ho										
BAL ter death. the funer yval.		John K	Hurst		57 F	rost Ave	nue Frostb	urg, Md.	21532			
BALT BOUND BOUTH BROWN BRO		IMMEDIATE CAUSE (Final	EDMPHOETIONS that caused to Liet only one cause on escape on escape. B. DUE TO (OR AS A C	OMA P					Approximate intervel Between Onaet and Death			
ath certificate be executed by significate by the signification and Hygiene prior to bur or other traumatic	CERTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	b DUE TO (OR AS A CONSEQUENCE OF): c DUE TO (OR AS A CONSEQUENCE OF): d									
at the dear by the att and Menta y injury,	CAL	PART II. Other aignificent condition	s contributing to deeth but	not resulting in	the underlyin	g cause given in			b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
requires that requires that sen signed b of Health ar	MEDI	DID TODA COO HEE CONT			PERFORMED? 1 YES 2 NO COMPL 1 YES 2 NO 1 YES							
4 9 E E	AN	DID TOBACCO USE CONTR		DEATH YES		UNCERTAI	N L					
SICIAN: The certificate the State in the State i, or item	PHYSICIAN:	1 YES 2 NO	HOSPITAL:		OTHER:	ne 5 🗆 Residence	6 ☐ Other (Specify)					
PHYSICIA r this certi th with the arked, or	ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY WO	URY AT ORK? YES 2 NO	28d. DESCRIBE HOW II	NJURY OCCURED				
DR ATTENDING PHYSICIAN: DIRECTOR: After this certifications after death with the St. tem 28 is marked, or it	8	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify,	Al home, lerm, st	reet, lactory, offic		281. LOCATION (Street a City or Town, State)	and Number or Rural	Route Number,			
DR ATTEN DIRECTOR: hours after item 28 is	COMPLET	29a. CERTIFIER 1 CERTIFYING PHYSIC	CIAN: To the best of my knowled	ige, death occurred	at the time, date	and place, and due	to the cause(a) and man	oner se stated				
HOSPITAL FUNERAL Within 72 I	OM		R: On the basis of axamination a						a) and manner as stated.			
THE HOSPI THE FUNEF filed within PORTANT:	BEC	29b. SIGNATURE AND TITLE OF CERTIFIER).			29c. LICENSE NUI			D (Month, Day, Year)			
PPS TO SO. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (TEM 27) (Type, Print)									▶ JULY 22, 1995			
/		ANGEL H	· ROQUE	TI (ITEM 27) (Type, I	48 1	anu Ter	race Fre	OSTALLE	We 21532			
6		31. DATE FILED (Month, Day, Year) JUL 24 1	32. REGISTAR'S SIRVAT	Wise Rod	W			7				

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		1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF		MENTA	L HYGIEN	Ε			
		1. DECEDENT'S NAME (First, Middle, Last) KATHRYN LUCIL	LE SM	ITH			2. DATE MONI Jul	OF DEATH	1995	EAR	TIME OF DEATH 17:10 M	
P	1	4. SOCIAL SECURITY NUMBER 219-03-9566	1 □ M 2 X F 80	(In yrs, last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mon	OF BIRTN th, Day, Year)	- 1	Country)	ACE (State or Foreign	
, 2, 3 should	DIRECTOR	9a. FACILITY NAME (If not institution, give alreet and number) MEMORIAL HOSPITAL CUMBERLAND ALLEGANY RESIDENCE OF DECEDENT										
permit, Pages 1,		10a. STATE 10b. COUNT	LLEGANY		T. SAVA						d. INSIDE CITY LIMITS? YES 2 NO	
sit	FUNERAL	100. STREET AND NUMBER 15928 FOUNDRY R				21545			U.S.A		T COUNTRY?	
D 21215-0020 spital or attending physician. red for use as the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 Merried 3 WWidowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DO	2 NO	If yes, s	CENDENT OF NISPA pecify Cuben, Mexic S 2 NO Speci	an, Puerto	N? (Specify Yea Rican, etc.)	or No— 14	Black, W Specify:	American Indian, hita, etc.	
	LETED	15. OECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	ICATION e completed) College (1-4 or 5+)	ille. Do NOT us	vork done during me e retired.)	ION ost of working	16b. KIND OF BUSINESS/INDUSTRY					
MARYLAND 21 retained by the hospital or 5 should be detached for untilled at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		HOUSE K	KEEPER	18. MOTNER'S NA	AME (First,					
MARY e retained b s 5 should 1 notified	TO BE	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
BALTIMORE, er death. Page 6 may be the funeral director, page val.		MARY L. COYLE FD#2 BOX#516 RIDGELEY, W.VA. 26753 20a METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of OiSPOSITION (Name of cametery, crematory or other piece) HILLCREST CEMETERY JULY 24 1995 CUMBERLAND MARYLAND										
BALIIMORE, after death. Page 6 may be at the funeral director, page moval. cal examiner must be		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MERRITT—ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND										
tely filled in the mation, or red		23. PART I. Enter the diseases, pr ahock, pr heart failure. IMMEDIATE CAUSE (Final disease pr condition resulting in death)	a. ACUTE MYOCA	ach ilne.	NFARCTIO		ch aa can	diac or reapi	atory arrest	,	Approximata Interval Between Onset and Death 5 days	
BOX 687(icate be executed physician and com per prior to burial, er traumatic ex	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	c	DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
OS, P.O. Be to death certificate the attending physicant Hygiene principle, or other tights.		that initiated events resulting in death) LAST	d									
ORD that the thed by the	EDICAL	PART II. Other algorificant condition Probable Seps		ut not reaulting in	n the underlyin	g cause given in	Part i.	24a. WAS AN PERFORM	MED?	CO	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH?	
TAL RECC The law requires ate has been signe ate Dept. of Healt tem 23 shows a	IAN: M	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐ 28. PLACE OF DEATH (Check only one)								YES 2 NO	
Certificant the St	PHYSICIAN:	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN	HOSPITAL: 1 Inpetient 2 ER/Outp 28a. DATE OF INJURY	atient 3 🗆 DOA	OTHER: 4 - Nursing Hon	ne 5 🗆 Raaldence	7					
	BY Pł	1 Naturel 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME INJU	M 1 🗆	JURY AT ORK? YES 2 NO	28d. DE:	SCRIBE HOW IN	JURY OCCUR	ED		
DIVISION OR ATTENDING R DIRECTOR: After hours after death item 28 Is mar	ETED	3 Suicide 6 Could not be detarmined	28s. PLACE OF INJURY building, etc. (Spec	eny)			City	ATION (Street as or Town, State)		Rural Ploute	Number,	
TO THE HOSPITAL OF TO THE FUNERAL DID BE filed within 72 ho	COMPL	(Check only one) 2 MEDICAL EXAMINE	ICIAN: To the beat of my knowl							ause(a) an	d mannar as stated.	
TO THE P TO THE P De filed v	TO BE	396. SIGNATURE AND TITLE OF CERTIFIES 30. NAME AND ADDRESS OF PERSON WIN	Negregi	town		29c. LICENSE NUI D 3328		P 29d. DATE SIGNED (Month, Day, Year) Duly 23, 1995				
/		Sunil Gupta M.D.	Johnson Hiegh	nts Medic		. Cumber	land	MD 21	1502	1		
6		31. DATE FILED (Month, Day, Year) JUL 24 1995	32. REGISTRAR'S SIGN	Mall								



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	OSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6	INCOMI DISCOURT ALL ALL ALL ALL ALL ALL ALL ALL ALL AL

3	1. DECEDENT'S NAME (Fin									2. DAT	E OF DEATH	DAY	YFAD	3. TIME OF DE	VТН
- 1	MISSOURI		LUCILLE		SHAN	1K		_		Jul		19	95	7:14	P
	4. SOCIAL SECURITY NUM 217-10-1		5. SEX	6. AGE (In	yrs. lest birth	RS. IF U	HB DAY		DER 24 HRS.	(Mor	E OF BIRTH oth, Day, Year)	97	e. BIRTI Count		Coreign
_	96. FACILITY NAME (# not					Aug 6, 1897 OR LOCATION OF DEATH 9c. COUNTY OF									
o l	MEMORIAL I			CUMBERLAND					ALLEGANY						
DIRECTOR	10s. STATE MD	Alle					CITY, TOWN OR LOCATION								Υ
- 10	10s. STREET AND NUMBER		gariy			Jumbe	mberland 101. ZIP CODE					LIMITS? 1\(\sum \text{ YES 2 \subseteq NO} \) 10g. CITIZEN OF WHAT COUNTRY?] NO
FUNERAL	108 Fourth Street							2150)2			USA			
à	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS OECEDENT EVER IN U.S. AF FORCES? 1 YES 2 WILLIAM FORCES? 1 YES 2 WILLIAM FORCES? 1 YES, GIVE WAR OR DATES						If yes,	S DECENDENT OF HISPANIC ORIGIN? (Specify is, specify Cubsn, Maxican, Puerto Rican, etc.) YES 2 X NO Specify:				es or No— 14. RACE — American Ind Black, Whits, etc. Specify: White		llen,	
ED	15. DE (Specify of	S	16a. DECEDE	nd of work de	one during	PATION 16b. KIND OF BUSINESS/III						viiice			
PLET	Elementary/Secondary	+)		ior use retin			Dept. Stores								
COMPL	17. FATHER'S NAME (First,	-12:			Decan	D CLC		16. M	OTHER'S N	ER'S NAME (First, Middle, Maiden Surname)					
BE	David Wakefield Mary										e (Tee				
၉	Ruby J. Si										nber, City or Tox				
	20s. METHOO OF DISPOSITION 1 Burlei 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place) 20c. LOCATION — City or To cemetery, cremetory or other place)											wn, State			
	4 Donotton 5 Other (Specify) Davis Memorial Cemetery 07/22 Cumberland, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY														
	Scarpelli Funeral Home Cumberland, MD 21502														
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reepiratory arrest, shock, or heart feiture. Liet only one cause on each line. IMMEDIATE CAUSE (Fine) Approximate interval Between Onset and Death														
Ŷ	disease or condition resulting in death) a. Cordia pulmany when 5 min Due To (OR AS A CONSEQUENCE OF):										1.				
LIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events b. Due to (or as a consequence of):														
CERTIFI	resulting in death) LAS		d											-	
MEDICAL	PART II. Other algnific	PART II. Other significent conditions contributing to death but not resulting 5/V hip sury; 2+							underlying ceuse given in Part I.			24a. WAS AN AUTOPSY PERFORMED?		WERE AUTOPSY I AVAILABLE PRIOF COMPLETION OF OF DEATH?	OT 1
	DID TOBACCO U	JSE CONTI	RIBUTE TO CA	AUSE OF	DEATH	YES [] NO	NN 🔁	CERTAI	N \square				1 🗌 YES 2 🗍	NO
SICIAN	25. WAS CASE REFERRED EXAMINER?	TO MEDICAL	HOSPITAL:		8. PLACE OF	OTH	IER:								
PH	1 Yes 2 No 1 Impetient 2 ER/Outpetient 3 7. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year)					TIME OF	TIME OF 28c. INJURY AT 28d. INJURY WORK?				8 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED				
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At homs, farm, street, factory, office building, stc. (Specify)						Tics 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLE			CIAN: To the best of R: On the base of a											and manner es	hetete
20	296, SIGNATURE AND TITL			_	vi.				ICENSE NU			29d, DAT	SIGNED	(Month, Day, Year,	

Johnson Heights Medical Bldg. Cumberland MD

2. DATE OF DEATH

July 6,

7. DATE OF BIRTH

(Month, Day, Year)
Oct. 19, 1953

1995

FOR STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

578-72-3862

10e. STATE

RESIDENCE OF DECEDENT

1, DECEDENT'S NAME (First, Middle, Lest)

Ralph Benjamin Shields

9s. FACILITY NAME (If not institution, give street and number

1 X M 2 | F

Malcolm Grow Medical Facility

10b. COUNT

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permit. Pages 1, 2, 3 should DIRECTOR D.C. Washington 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE hours after death. Page 6 may be retained by the hospital or attending physician. So in by the funeral director, page 5 should be detached for use as the burial-transit 3030 30th Street S.E. 20020 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO FORCES? 1 1 Yes 2

IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cubsn, Mexican, Pusrto Rican, stc.) 1 Never Married 2 Married 1 TYES 2 NO Specify: BY 3 Widowed 4 Divorced 18e. BECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 6 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high E Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Navy COMPL Aircraft Mechanic 12grade 17. FATHER'S NAME (First, Middle, Lest) 1a. MOTHER'S NAME (First, Middle, Maiden Sumame) 7 Joe Nathan Shields BE Elizabeth Bennaugh notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Shields Caridad A 30th St. Washington, 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery must be 20s. METHOD OF DISPOSITION
1 💢 Burlel 2 🗆 Cremation 3 🗆 Removal from State 20c. LOCATION - City or Town, State DATE Donation 5 - Other (Specify) -95 ona 1 medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robinson Funeral Home Busin completely filled in by the rial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease Dr condition Pulmonary Embolism reauiting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE DF): the death certificate be executed burial, Presumed Deep Vein Thrombosis
DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION and Sequantially list conditions, prior to If any, leading to immediate has been signed by the attending physician Dept. of Health and Mental Hygiene prior to e. Entar UNDERLYING Gangrenous Right Lower Extremity
DUE TO (OR AS A CONSEQUENCE OF): CAUSE (Disease Dr injury that initiated events reaulting in death) LAST Diabetes Mellitus 9 injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? requires that shows any 1 X YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) Item r this certificate h HOSPITAL:
1X inpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO ng Home 5 - Residence 8 - Other (Specify) the p 27. MANNER OF DEATH 28e. DATE OF INJURY is marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) a Could not be COMPLETED 4 Homicide 28 ltem. 29s. CERTIFIER 1 🔯 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and piecs, and due to the cause(e) end manner se stated. TO THE HOSPITAL IN TO THE FUNERAL D be filed within 72 ho 2 MEDICAL EXAMINER: On this basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to this cause(s) and menner as stated. 29h. SIGNATURE AND JITLE OF CENTERE 29c. LICENSE NUMBER BE D 4475 Md 2 AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 89 MDG 1050 W Perimeter Rd Andrews AFB, Md 31 Michael P. Salata, Cpt, USAF, MC 32. PEGISTRAR'S ŞIGNATURI 31. DATE FILED (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

10c. CITY, TOWN OR LOCATION

IF UNDER 24 HRS.

Andrews Airforce Base

9b. CITY, TOWN OR LOCATION OF DEATH

6. AGE (In yrs. last birthday)

YRS.

41

3. TIME OF DEATH

AM

04:55

10d. INSIDE CITY LIMITS?

1X YES 2 □ NO

a. BIRTHPLACE (State or Foreign

Wash., D.C.

SuitlandMaryland

14. RACE — American Indian, Black, White, etc.

Specify Black

D.C.20020

Arlington Va.

1313 6th N.W.

Wash. D.C.2001

Approximata

interval Batwe

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

▶ July 10, 1995

Onset and Death

9c. COUNTY OF DEATH 2762

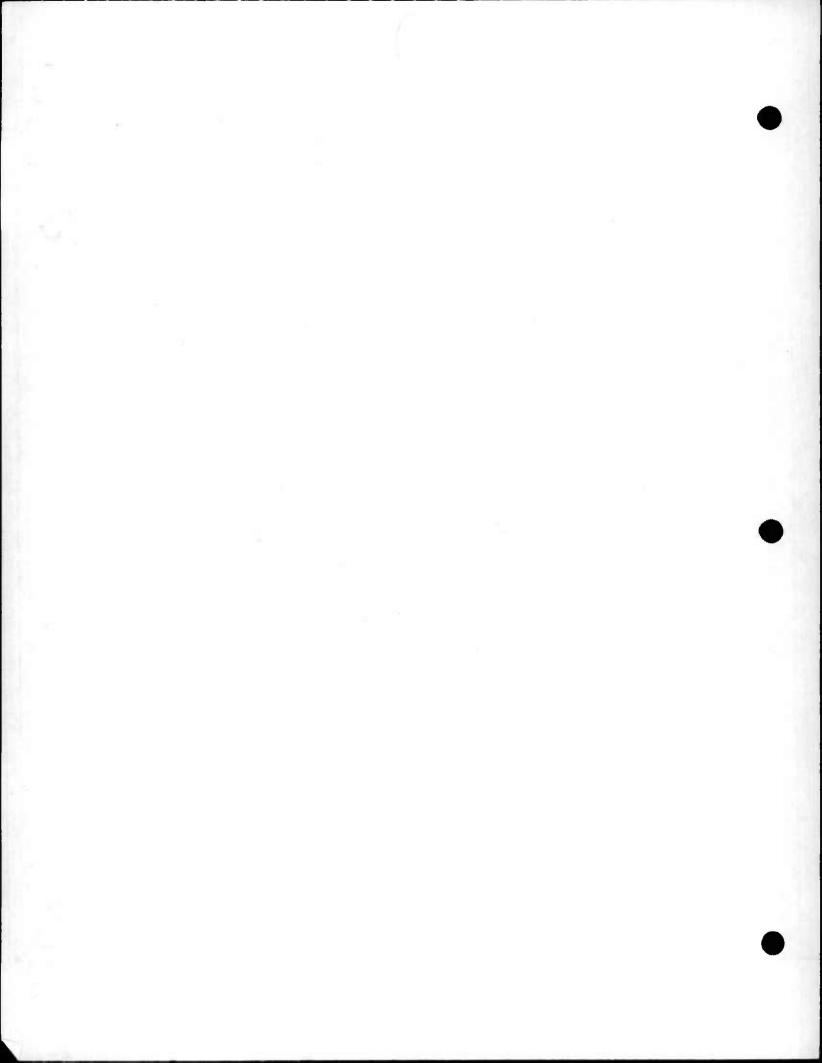
10g. CITIZEN OF WHAT COUNTRY?

U.S.A.

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		REGISTRAR		CERTIF	ICATE C	OF DEATH	REG. NO).	
		1. DECEOENT'S NAME (First, Middle, Last)	T	ST	ONE		2. DATE OF OEATH	5-198	3. TIME OF OEATH
P		4. SOCIAL SECURITY NUMBER 428 26 9978	1 - M 2 XF 8	(In yrs. lest birthday)	IF UNDER 1 YEA		7. DATE OF BIRTH (Month, Day, Year) Jan. 6, 1		BIRTHPLACE (State or Foreign Country) ississippi
2, 3 should	TOR	9a, FACILITY NAME (If not institution, give str LARKIN CHA RESIDENCE OF DECEDENT	SE N. F	OME	Bowie	VN OR LOCATION OF O	EATH	9c. COUNTY Prince	of OEATH e George's
it. Pages 1,	DIRECTOR	10a. STATE 10b. COUNTY Mississippi Lee			y, TOWN OR LO	OCATION			10d. INSIDE CITY XX LIMITS? 1 YES 2 NO
n. ansit permit.	FUNERAL	10e. STREET AND NUMBER 2880 W. Main St	treet			101. ZIP CODE 3880:	3		of what country?
215-0020 attending physician. se as the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR DA	2 2 NO	If yes	OECENOENT OF HISPAI , specify Cuban, Maxics YES 2 NO Specif		s or No- 14.	RACE — American Indian, Black, White, atc. Specify: White
or after	ETED	15. OECEDENT'S EOUC. (Specify only highest grade of Elementary/Secondary (0-12)		life. Do NOT us	vork done during se retired.)	ATION I most of working	18b. KINO OF BU		TRY
The hospital detached to once.	COMPL	17. FATHER'S NAME (First, Middle, Last)		Teache	r	18. MOTHER'S NA	Pu ME (First, Middle, Maiden	blic Sc	hool
H P P P P P P P P P P P P P P P P P P P	III	Arthur Eugene '.	<u> Fanner</u>	19b. MAILING	AOORESS (Str		Pearl Mc D		10)
Y be re sage 5		Arthur Charles Tai		12309	Melod	y Turn Boy	wie Maryla	nd 2071	15
e 6 m rector.		1 Burlal 2 Cremation 3 Ramon 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	val from Stata cam	netery, crematory or of Odd Fello	ther place) NS Cem	etery	Oko	lona Mi	or Town, Stata
Ex Fe D		▶ Robert E.	Evans.	Pres.	Rob	00 Annapo	ans Funera lis Rd. Bo	wie Md.	20715
be executed within 24 hours cian and completely filled in for to burial, cremation, or re raumatic event, the med		23. PART I. Enter the diseases, or co ahock, or heert failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	ASPIR OUE TO (OR AS A	d the deeth. Do n ach line. ATT (CONSEQUENCE OF	= CA	> RESP	PATORY	FAIL LUNC	Interval Between Onset and Death
S, P.O. Bod death certificate attending physicartal Hygiene print, or other to	SERTIFI	thet initieted eventa resulting in death) LAST	DYSPH	A GI	À.				>3-w/s.
Jires that the death signed by the atte Health and Mental ws any Injury, o	DICAL	PART II. Other algnificant conditions	contributing to deeth be	ut not resulting l	n the underl	ying cause given in	Part I. 24s. WAS AN PERFOI	RMEO?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
L KE law requast been lept. of 23 sho	2	DID TOBACCO USE CONTRI					√ _∞ γ		1 O YES 2/O NO
F VIIAL SICIAN: The lav certificate has the State Dep		EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outp	26. PLACE OF OEAT	QTHER:	iome 5 🗆 Rasidenca	8 Other (Specify)		
The state of	ву Рн	27. MANNER OF DEATH 1 Natural 5 Pending Accident Investigation	28a. QATE OF INJURY (Month, Day, Year)	28b. TIME INJI	URY M	INJURY AT WORK? YES 2 NO	28d. OEŞCRIBE HOW	NJURY OCCURE	:0
OR ATTENDING OR ATTENDING DIRECTOR: After hours after death tem 28 Is ma		3 Suicide 8 Could not be detarmined	28a. PLACE OF INJURY building sic. (Spec	— At home, ferm, s	treet, factory, o	offica /	City or Toyn, State	and Number or Ri	ural Route Number,
A HOF			IAN: To the best of my knowl : On the basis of examination						use(s) and manner as stated.
TO THE HOSPIT TO THE FUNER be filed within 7	8	29b. SIGNATURE AND TITLE OF CENTRAL	000	0		D-3 U	S25	29d. OATE SIG	3NEO (Month, Day, Year) 7-12-95
6	욘	30. NAME AND ADDRESS OF PERSON WHO	COMPLEXEDICAUSE OF DE	ATH (ITEM 27) (Typo,	Print) 22	0; BOL	WE-N	W-	20716.
		31. OATE FILEO (Month, Dey, Year) JUL 19 1995	32 REGISTRAR'S SIGNA	ATURE			· · · · · · · · · · · · · · · · · · ·		

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	DITAL OF ATTENDING BUYCHAN. The law requires that the death cariforns he executed with
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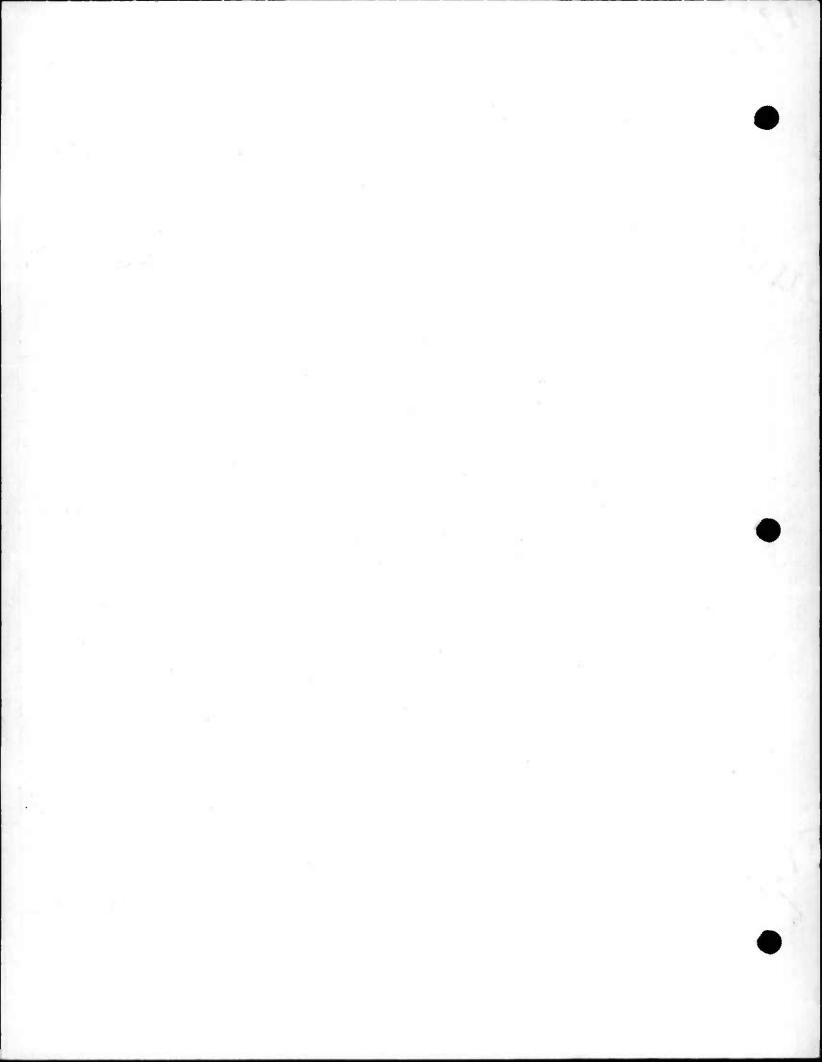
31. DATE FILED (Month, Day, Year)

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alia Davidson Revolate

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH JÜLŸ 15, 1995 7:52pm THOMAS NEILL TURNER 7. DATE OF BIRTH (Month, Day, Year)
DEC. 17, 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 1 M 2 | F 577.10.9850 79 1915 WASHINGTON D.C. funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give etreet end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND MONTGOMERY BETHESDA XX YES 2 NO FUNERAL 10e. STREET AND NUMBE 10f ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 9128 KIRKDALE ROAD 20817 U.S.A. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, stc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 NO 1 Never Married 2 Merried BY Specify: WHITE 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b, KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4,or 5+) AUDITOR U.S. GOVERNMENT 17. FATNER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at JOSEPH W. TURNER BE VIOLET RIDGELY 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 9 MARGUERITE L. TURNER 9128 KIRKDALE RD. BETHESDA, MD. 20817 9 20e. METNOD OF DISPOSITION
1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must MT. COMFORT CREMATORY 7/20 ALEXANDRIA, VA. 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLERS SONS lah 5130 WI AVE NW WASHINGOTN DC 20016 the medicai 23. PART J. Enter the diseases, preprinciples that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. filled in by Approximata shock, or haart failure. List only one cause on each line. intarvai Between ō **IMMEDIATE CAUSE (Final** Onset and Dapth cremation. event, the disease or condition resulting in death) Ke sprator immeduly completely and con burial, iong traumatic CERTIFICATION standing Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF 9 oe ing physician a Hygiene pri if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST attending 6 the atten Mental I PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? Failure 1 YES 2 NO shows a 1 YES 2 NO t. of ! DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square has by Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE DF DEATH (Check only one) certificate h HOSPITAL: 1 YES 2 NO TUZ Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) the 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c 28b. TIME OF INJURY marked, 1 Natural 5 Pending 1 YES 2 NO ВУ After 1 death 2 Accident Investigation 3 Sulcide 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 Is COMPLETED 8 Could not be DIRECTOR: , 4 Homicide 290. CERTIFIER 1 _ CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated. FUNERAL 1 within 72 ? = TO THE HOSPITA
TO THE FUNERAL
Be filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the besie of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE Yaul 2 COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 30, NAME AND ADDRESS OF Paul Ira



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should be detached for use as the burial-transit

notified at

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31. DATE FILED (Month, Day,

9 1995

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

Davidson Randall

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be
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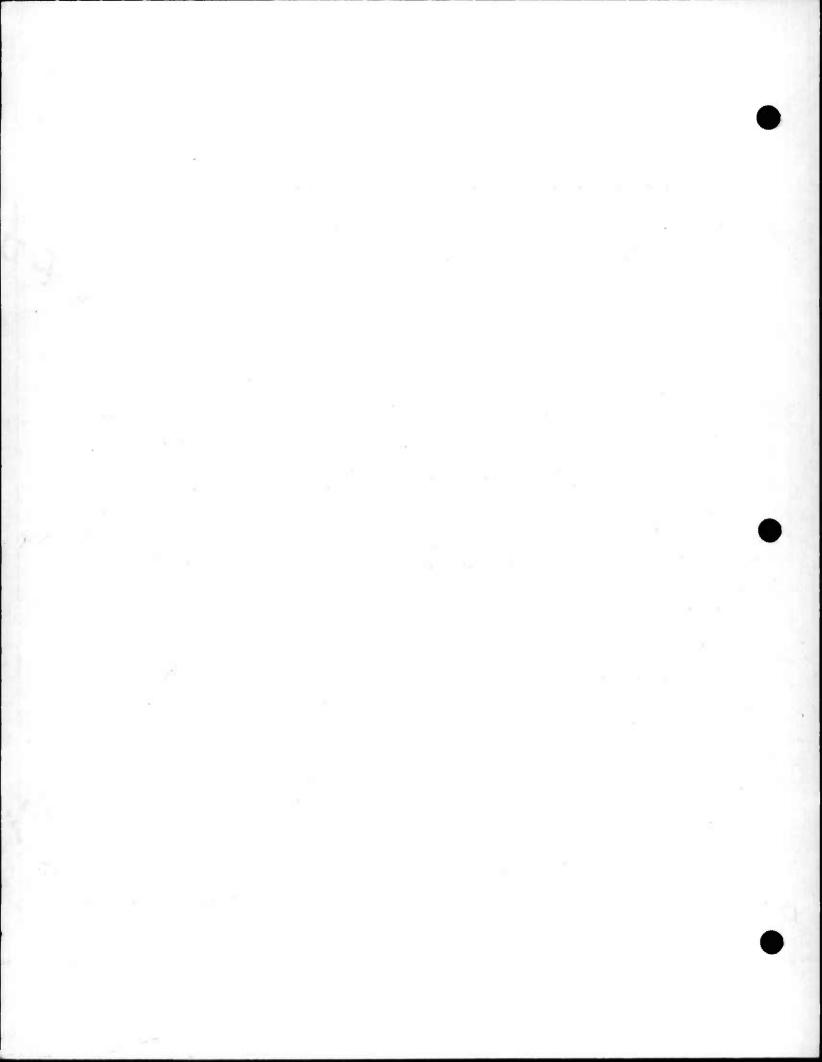
95 231,44 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATN MORGAN 995 HOMAS 1822 JULY 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday IF UNDER 1 YEAR | IF UNDER 24 HRS 7. DATE OF BIFTN (Month, Day, Year) S. BIRTNPLACE (State or Foreign 63 201-24-5399 1 X M 2 - F 1931 Dec. 18, Pennsylvania 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN DIRECTOR Shady Grove Adventist Hospital Rockville Montgomery RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Rockville 1 YES 2 NO 10a STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4705 Jasmine Drive 20853 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES Korea 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Merried BY 3 Widowed 4 Divorced White 18e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 4 Territory Supervisor Sears 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surneme) Morgan Philip Thomas, Sr. BE Dorothy Steever 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Beverly G. Thomas 4705 Jasmine Drive, Rockville, MD 20e. METNOD OF DISPOSITION

1 Seriel 2 Cremetion 3 Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Norbeck Memorial Gardens 7/20/95 4 Donation 5 Other (Specify) Olney, MD 21. SIGNATURE OF FÜNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. OR male 500 University Blvd.W. Sil.Spr.MD 20901 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raepiratory arrest, shock, or heart failure. List only one cause on each light. Approximate interval Batween **IMMEDIATE CAUSE (Finel Onset and Death** lectionin, Refractor. MYELOGENOUS disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): neuman, A NO. Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CERTIFICATI CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not reaulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? PERFORMED? 1 | YES 2 10 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO atient 2 ER/Outpatient 3 DOA 4 Nursing Name 5 Residence 6 Other (Specify) 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT WORK? 26d. DEŞCRIBE NOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO В Investigation 2 Accident 3 Sulcide 28e. PLACE OF INJURY — At home, farm, atreet, fectory, office building, atc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Nomicide determined 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. MIR: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end pieca, end due to the ceuse(e) end manner ee stated, 295 SIGNATUR 29d. DATE SIGNED (Month, Day, BE 29c. LICENSE NUMBER

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	AL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page		
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PITAL D	RAL DI	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	T: If ite
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95 23445 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last)
Zeleka Tafese 2. DATE OF DEATH 3 TIME OF DEATH . ******1995 July 11, 10:15 AM M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year July 22 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 546-91-5875 1 M 2 TF 66 Ethiopia 1928 9a. FACILITY NAME (If not institution, give atreet and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Suburban Hospital DIRECTOR Bethesda Montgomery RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Alameda California Oakland 1 XYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1600 Lakeshore Blvd #208 94606 Ethiopia 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 24 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: IF YES GIVE WAR OR DATES BY ₩idowed 4 Divorced SBYack COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Lest) 16. MOTHER'S NAME (First, Middle, Malden Surname) H Mikael Tafese Belayneh Mulatwa BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Elias Negash 2025 Fairmont Dr., San Mateo, Calif. 94402 9 20a, METHOD OF DISPOSITION
1 Description | Method | Burlel | 2 | Cremation | 3 | Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata DATE must Serbian Cenetery 7/15/95 San Mateo, Calif. 4 Donation 5 Other (Spec examiner Arlington Funeral Home 3901 N. Fairfax Dr., Arl., Va. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate shock, or heart failure. List only one cause on each line. interval Betv IMMEDIATE CAUSE (Final **Onset and Death** ile ile disease or condition ardiohi resulting in death) DUE TO (OF AS A CONSEQUE CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) OTHER: 1 TYES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA nca 8 - Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, streat, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the ba ation end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29h SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Kekesh 11.93 9

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1995 8

32. REGISTRAR'S SIGNATURE

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within-z4 hours after death. Page 6 may be retained by the hospital or attending physician.	hours after death. Page 6 may be retained by the hospital or attending physician,
"TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal,	erificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	medical examiner must be notified at once.

95 23446 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 HELENA TAYLOR July 12, 1:40 AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign (Month, Day, Y 1 M 2 X F 217-07-2127 D 87 YRS. August 5, 1907 Maryland 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Meridian Nursing Home Silver Spring Montgomery RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Silver Spring 1 - YES 2 1 NO FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 14221 Cantrell Road 20905 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married В 1 YES 2 NO Specify: 3 🔀 Widowed 4 🗌 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade come Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Herbert A. Simpson Annie R. Bandel BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles Simpson 14221 Cantrell Road, Silver Spring, Maryland 20905 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 1 🖹 Burial 2 □ Cremation 3 □ Removal from State Druid Ridge Cemetery 4 Donation 5 Other (Specify) 7/14 Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITYHINES-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, MD 20904 aine 23. PART/I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart failure. List only one cause on each line. interval Betwe IMMEDIATE CAUSE (Final Onset and Death disease or condition ACUTE Myocardial INFARCTION
DUE TO (OR AS A CONSCOUENCE OF): reaulting in death) MinuTes ARTERY DISEASE OROMARY A O YRS Sequentially list conditions. if any, leading to immediate CERTIFICAT cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE Chonic Renal Disease 1 | YES 2 | NO DE DEATH? caute GII Bleeding 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 X Nursing Home 5 - Rasidence 6 - Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26c. INJURY AT WORK? 26d. DEŞCRIBE HOW INJURY OCCURED Natural 5 Pending Investigation М 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) ETED 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide determined 29a. CERTIFIER (Check only Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. COMPL 2 __ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

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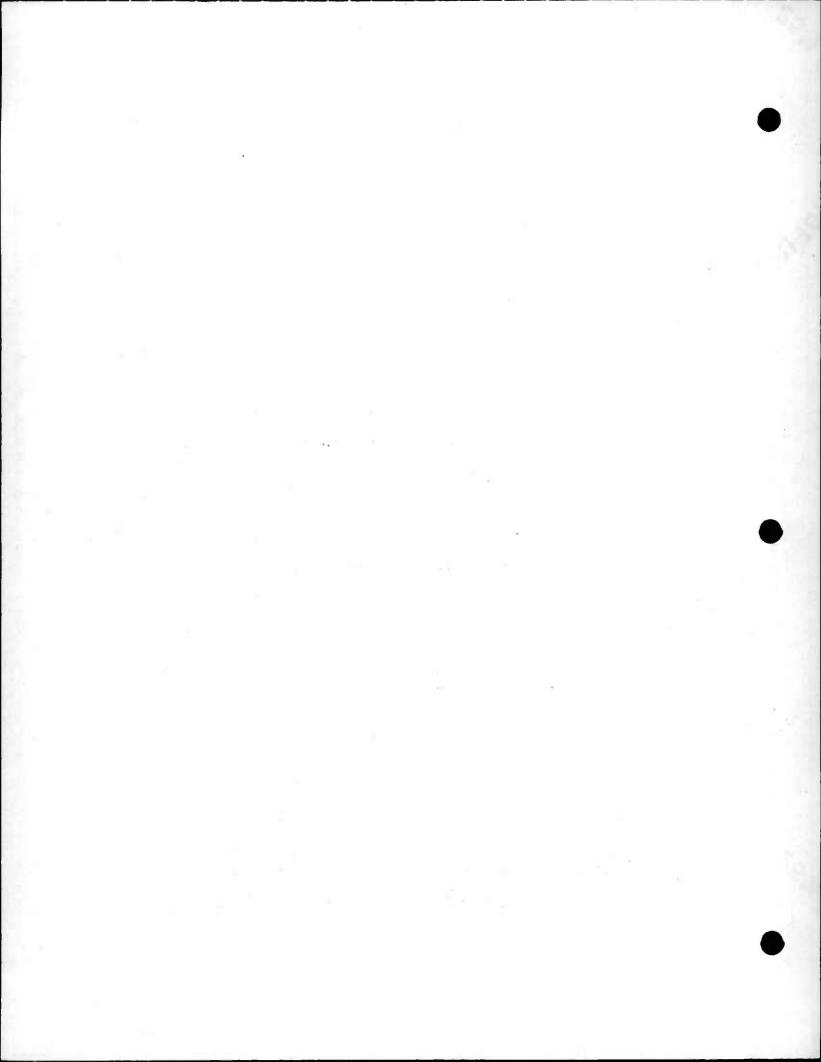
ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

JULY OF WHILE THE SIGNATURE

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Randolph Rd, Rock ville, md 2083

29d. DATE SIGNED (Month, Day, Year)



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	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.		
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5	DIRE	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified a
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

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42. REGISTRAR'S SIGNATURE

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31. DATE FILED (Month, Day, Year)
JUL 17 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH July 14 1995 3:10A Tetlow Elizabeth Mary 7. DATE OF BIRTH JUNE 21,1906 4. SOCIAL SECURITY NUMBER 5. SEX 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 216-18-0754 89 1 🗆 M 2 🔀 F YRS. MARYLAND 9e. FACILITY NAME (If not institution, give etreet and number, 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Washington Fahrney Keedy Home Boonsboro RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND WASHINGTON HAGERSTOWN 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 19609 COOL HOLLOW DRIVE 21740 UNITED STATES 12. WAS DECEOENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yae or No-if yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Married B 1 YES 2 NO Specify. Specify.WHITE 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18e. OECEDENT'S USUAL OCCUPATION 18b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade compl (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) 11 0 HOMEMAKER OWN HOME 17, FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surnan WILLIAM HOWARD TRAIL MATTIE EDNA 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Co-2 GARY L. BEALL 9609 COOL HOLLOW DRIVE HAGERSTOWN, MD. 21740 21e METHOO OF DISPOSITION
1 Burlel 2 Cremellon 3 Removal from State
4 Donetlon 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, Stata PARKLAWN CEMETERY 7/17/95 ROCKVILLE, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE MURIEL H. BARBER FUNERAL HOME Murie BOX 5038 LAYTONSVILLE, MARYLAND .0. 23. PART i. Entar the disease es, or complications that caused tha death. Do not anter tha mode of dying, such as cardiac or reapiratory arrest, Approximate shock, or heart fallure. List only one cause on each line. Intarvai Batween **IMMEDIATE CAUSE (Final** Oneat and Dasth disasse or condition Premonia resulting in death) DUE TO (OR AS A CONSEQUENCE OF): NO Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CERTIFICATI CAUSE (Disesse or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated evants resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? MEDICAL 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 4-NO 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL 1 TYES 2 DINO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA rsing Home 5 Residence 6 Other (Specify) 27. MANNER OF OEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Waturel 5 Pending 1 YES 2 NO В Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, streat, factory, office building, etc. (Specify) 3 Sulcida 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER
(Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner se stated. (Check only one) 2 MEQICAL EXAMINER: On the basic of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Freemo

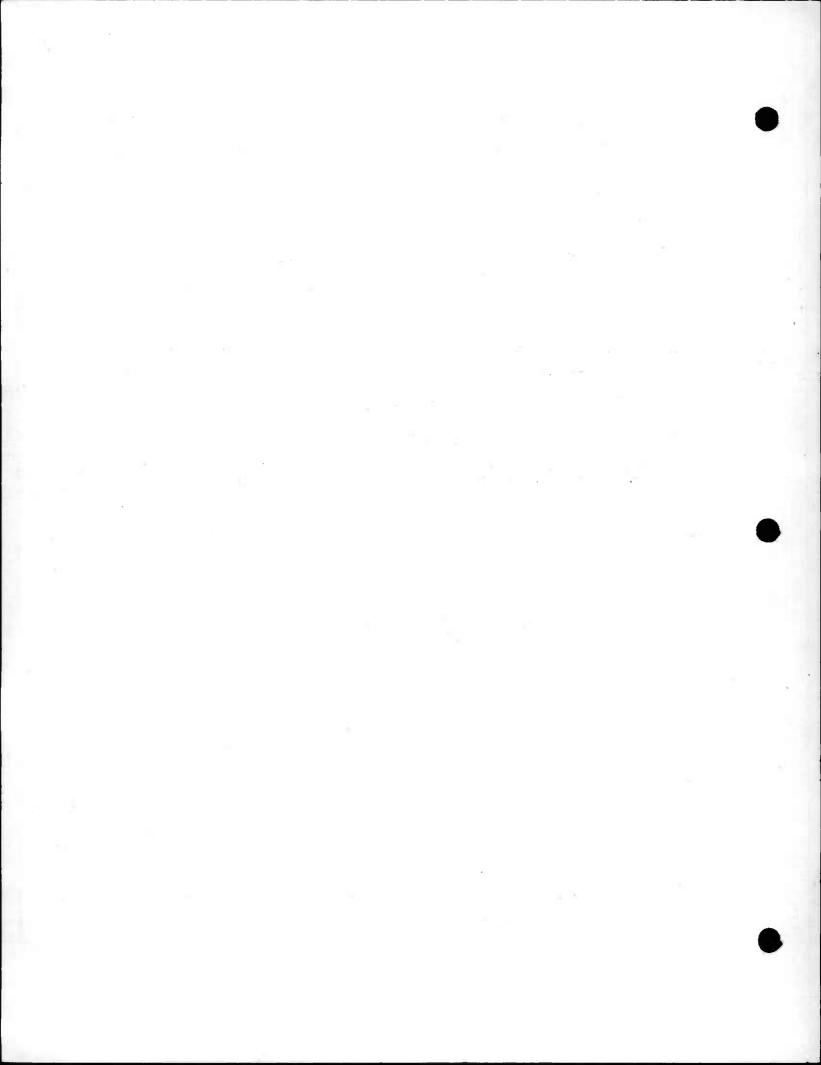
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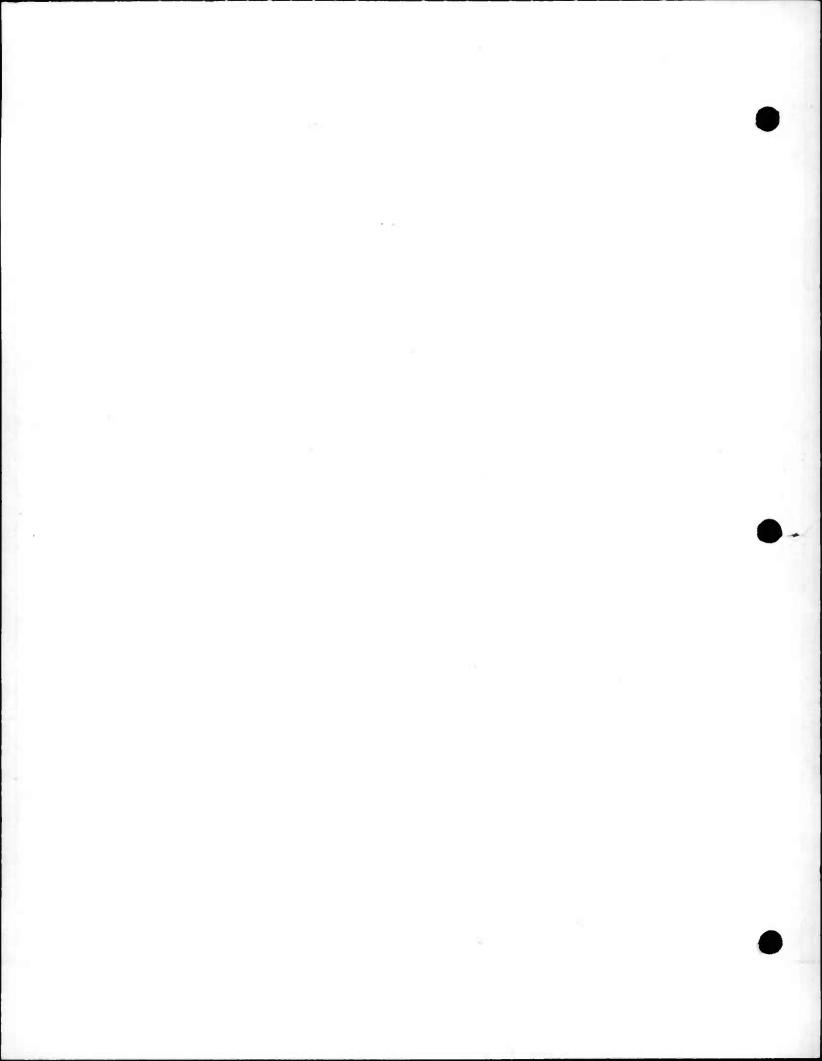
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		1 - FOR STATE REGISTRAR		STATE OF M	ARYL			MENT OF I	HEALTH AND	MENT	AL HYGIE				
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-AND 21215-0020 the hospital or attending physician. detached for use as the bunial-transit once.	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Mr 2 Notes All Divorce	arried	2. WAS DECEDENT FORCES? WA IF YES, GIVE WA	YES	2 NO	D	13. WAS DEC	CENDENT OF HISPA Becity Cuben, Maxic 3 2 NO Speci	an, Puert	GIN? (Specify Y o Rican, stc.)		Specify:	- American in Whife, atc.	ndlan,
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MAR retained 5 should notified	2	Edna Uhl	,			- 1			ee Lane					21501	
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BALIIMORE, or death. Page 6 may be the funeral director. page val.		4 Donation 5 Other (S)	3 Ramovi	il from State	Re	etery, cremet stlaw	tory or oth	emorial	Gardens	07/		Vale,			
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0 0 0 5	E	PART II. Other significent	conditions	contributing to d	e eth hu		ulalm = 1m	45 4		-	1		_		
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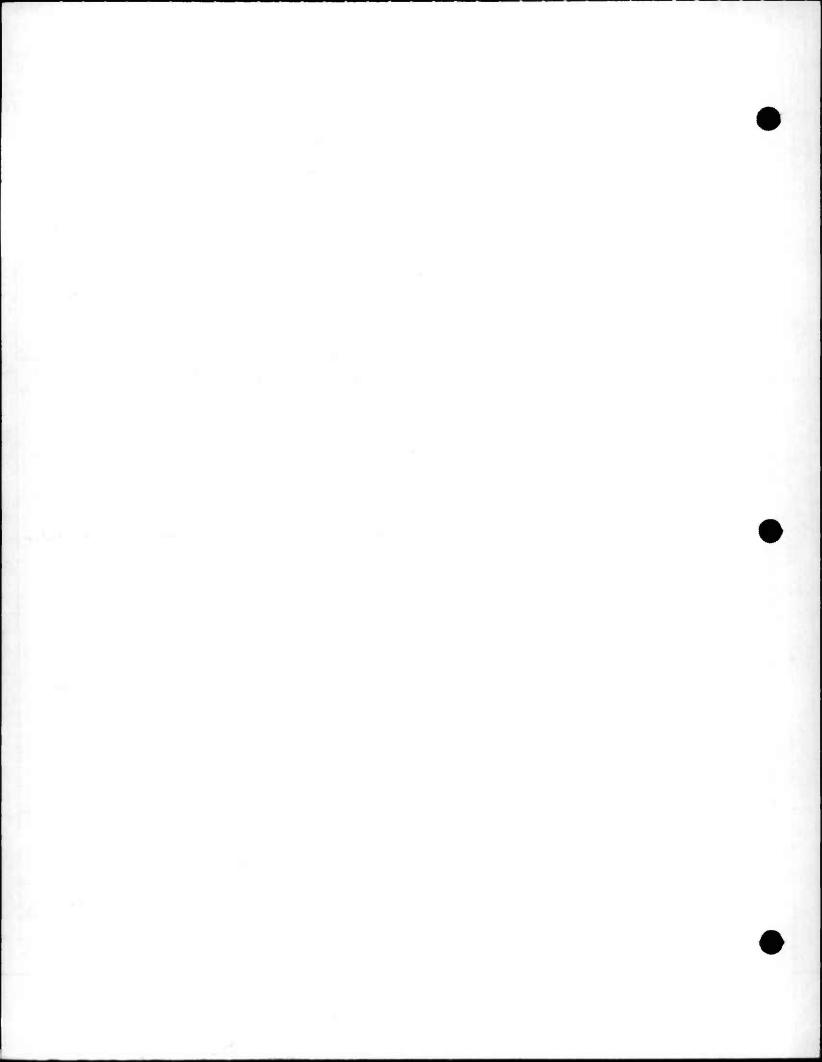
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
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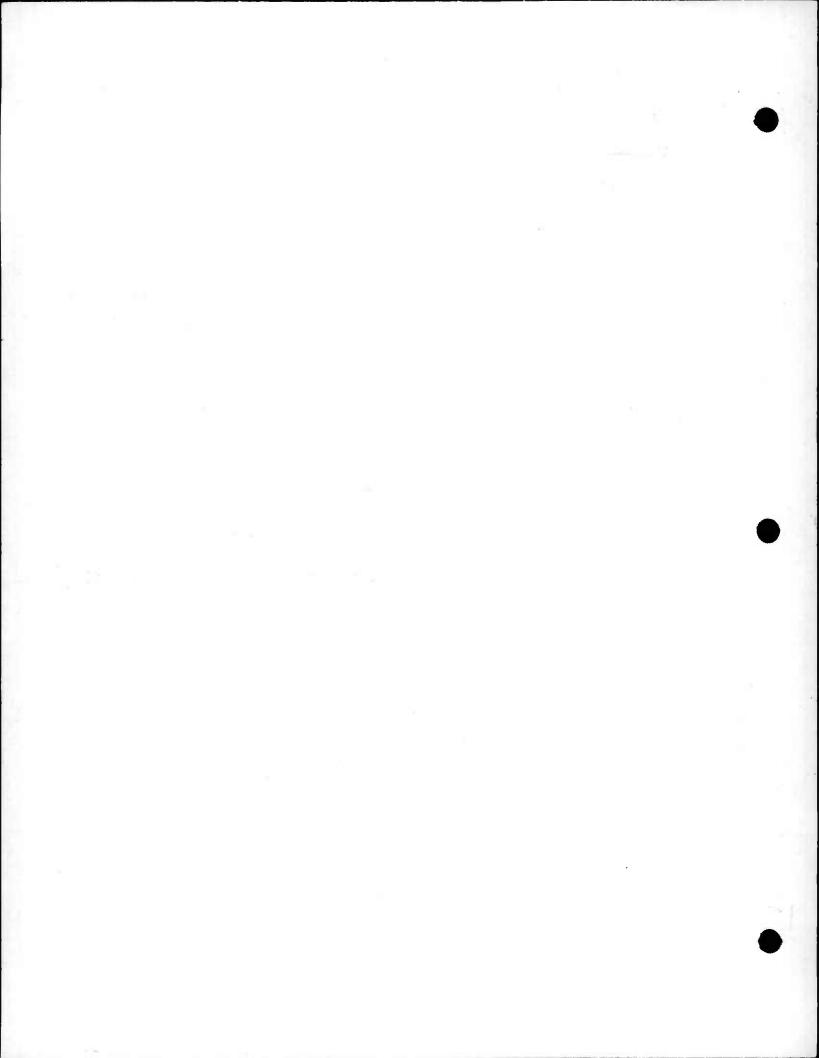
1	1. DECEDENT'S NAME (First, Middle	e, Last)						2. DATE OF DE	EATH			IME OF DEATH	
	PAULINE V	1995 ՝	YEAR 7	:30 A M									
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. less		IF UNDER 1 Y		R 24 HRS.	7. DATE OF BIS (Month, Day,	RTH	BIRTHPLAC	CE (State or Foreign		
	220-28-5118	1 □ M 2 💢 F	85	YRS.	MONTHS D	HOURS	VIRGII	NIA					
_	9a. FACILITY NAME (If not institution				96. CITY, TO	WN OR LOCATI	ON OF DEA	AUG. 30			Y OF DEATH		
DIRECTOR	HOME COVE I				GAI	THERSBU	JRG			MO	NTGOM	IERY	
EC	10s. STATE 10b.	COUNTY		10c. CITY	TOWN OR L	OCATION					10d	INSIDE CITY	
	MARYLAND M	ONTGOMERY		GA3	THERS	BURG						YES 2 NO	
FUNERAL	100. STREET AND NUMBER 23605 WOODFIE	LD ROAD				10f. ZIP COD	2088	32			N OF WHAT	COUNTRY?	
N	11. MARITAL STATUS		NT EVER IN U.S. ARI	MED	13. WAS	DECENDENT (OF HISPANH	C ORIGIN? (Spe	ecify Yes or	r No 14	I. RACE — A	merican Indian,	
BY	1 Never Merried 2 Marrie 3 Wildowed 4 Divorced	FORCES?	1 YES 2 N	10	It ye	NES 2 NO	m, Mexican.	, Puerto Rican.	atc.)		Black, Whi	NHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (She kind of work done during most of working													
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5	+) ///e.	Do NOT use	retired.)		-	00111	ITV C		DILIC		
MP	11	0	рсни	OF BC	JS ATT	ENDANT		COOK	ALY 2	CHOOL	- RO2		
BE CO	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) KATIE HOLSINGER												
10	196. INFORMANT'S NAME (Type/Print) JUDY V. MOORE 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20912 BROOKE KNOLLS ROAD GAITHERSBURG, MD. 20882												
	20a METHOD OF DISPOSITION 1 A Burls1 2 Cremation 3 4 Donation 5 Other (Special		20b. PLACEA				7/1	DATE 18/95	20c. LOCA	TION — CIE	y or Town, S E, MAI	tata RYLAND	
	21. SIGNATURE OF FUNERAL SER	VICE LICENSEE	0 1		22, NA	E AND ADDRE							
	22, NAME AND ADDRESS OF FUNERAL HOME 20882 P.O. BOX 5038 LAYTONSVILLE, MARYLAND												
	23. PART i. Enter the disease ahock, or heart for	s, or complications the	nt causad the dea	ath. Do no	ot antar the	moda of dy	ing, such	aa cardiac o	r reapirat	tory arrea	t,	Approximate interval Between	
	IMMEDIATE CAUSE (Final				0			2			į	Onaat and Daath	
	disease or condition resulting in death) Due to (OR AS A CONSEQUENCE OR)												
	DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	b. DUE TO	(OR AS A CONSEO	UENCE OF)	:								
CAT	cause. Entar UNDERLYING)									į		
Ë	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSEQ	UENCE OF)	:								
ERI	resulting in death) LAST	d											
	PART ii. Other aignificant co	nditions contributing to	daath but not ra	auiting in	tha undar	iying cause (iven in P	art i. 24a. 1	WAS AN AU	TOPSY	24b, WFRI	E AUTOPSY FINDINGS	
MEDICAL.								,	PERFORME		AVAIL	ABLE PRIOR TO PLETION OF CAUSE	
ED								'''	YES 2 🔄	MO		EATH? YES 2 TNO	
	DID TOBACCO USE C	ONTRIBUTE TO CA	USE OF DEAT	TH YES	S □ NC	□ UNC	ERTAIN					TES 21 NO	
S	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)												
YSI	1 TYES 2 NO	HOSPITAL:	ER/Outpatient 3		OTHER:	Home 5 🗆 Ra	sidence 8	Other (Spec	elly) g	vous	Home		
BY PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pendin 2 Accident Investi		INJURY Pay, Year)	28b. TIME INJU	RY	INJURY AT WORK?		28d. DESCRIBE	HOW NJU	URY OCCUR	RED		
COMPLETED B	2 Accident Investig 3 Suicide 8 Could 4 Homicide datarm	28s. PLACE (OF INJURY — At honests. (Specify)	ne, ferm, st	reet, factory,	office	1	28t. LOCATION City or Town		Number or	Rural Route I	Number,	
91	29a. CERTIFIER	DHYSICIAN, To the best of											
₹ I		PHYSICIAN: To the best of											
	WEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and placs, and due to the cause(s) and manner as atsted.												
	29b. SIGNATURE AND TITLE OF CE	RTIFIER				I Z9c. LICE	NSE NUMB		1 2	OH DATE OF			
O BE		u ()				103	191	8		▶ JUL	Y 15,	1995	
TO BE	1115601115	u ()	SE OF DEATH (ITEM	Leese	en Cu	103	191	Selver		▶ JUL	Y 15.	1995	
	30. NAME AND ADDRESS OF PERS	ON WHO COMPLETED CAU	SE OF DEATH (ITEM Note AR'S SIGNATURE Wilson Rayl	Leese	erine)	103	191	Selve		▶ JUL	Y 15.	1995	



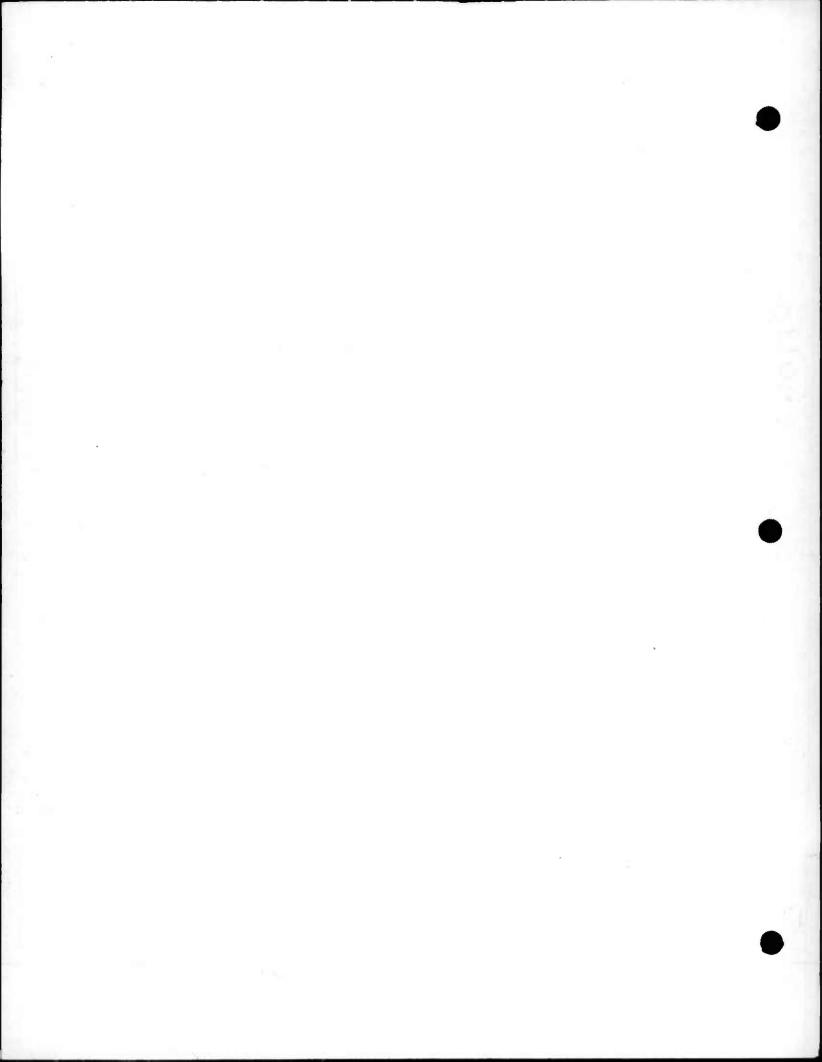
Dialo

CONTROMS. Area mis certificate has been signed by the automorphy property lined in by the furnity and permit, Pages 1, 2, 3 st hours after death with the State Dept, of Health and Mental Hygiene prior to burlar, cemation, or removal.	DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	DALLIMONE, MANTENDO
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Items1.4 8-22-95 FilmG726 W.H.Per F/H 195 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) Vasilios Xereas 2. DATE OF DEATH 3. TIME OF OEATH 4:50 A M 17 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 573-58-6329 1 X M 2 - F 50 Jan. 1945 Greece 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR John Hopkins Bayview Medical Center Baltimore RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Montgomery Silver Spring 1 XYES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 930 Venice Drive 20904 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Bleck, White, etc. 1 Never Merried 2 X Merried BY 1 YES 2 NO Specify: 3 Widowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INOUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Chauffer Journalism 6 0 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ John Xereas Antonia Rougnis BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Irene Xereas 930 Venice Drive, Silver Spring, Maryland 20904 90 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State MUST 1 XBuriel 2 Cremetion 3 Removal from State
4 Donation S Other (Specify) camatery, crematory or other place) Gate of Heaven Cemetery 7/21 Silver Spring, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD педісаі 23. PART I. Enter the diseeses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reepiratory errest, shock, or heert feilure. List only one cause on each line. Interval Between **IMMEDIATE CAUSE (Fine) Onset and Death** E E disease or condition resulting in death) event, QUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly liet conditions. DUE TO (OR AS A CONSEQUENCE if eny, leeding to immediate cause. Enter LINDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not recuiting in the underlying ceuse given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TYES 2 TO NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation М 1 YES 2 NO ВУ 2 Accident 28a. PLACE OF INJURY — At home, farm, straet, tectory, office building, etc. (Specify) 3 Sulcide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 8 Could not be 4 Homicide determined 29e. CERTIFIER COMPL 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, end due to the cause(a) and menner as stated. TO THE HOSPITAL
TO THE FUNERAL I
De filed within 72 h
IMPORTANT; #f ii (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data end pieca, end due to the cause(e) end menner ee stated. 296. SIGNATURE AND THE OF CERTIFIE 29d. OATE SIGNED/ (Month, Day) 29c. LICENSE NUMBER BE Manne 0



		FOR 1 - STATE REGISTRAR	STATE OF M					IEALTH AN DEATH	D MEN					
		1. DECEDENT'S NAME (First, Middle, Last)			CERTIF	ICATE	UF	DEATH		REG. NO		3.	TIME OF DEATH	
			Isaac	Van d	er Hov	Hoven				JULY 18, 1995			2.00 A M	
	- 1	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs			ZAYS	IF UNDER 24 HF	s. 7. D/	TE OF BIRTH onth, Day, Year)		. BIRTHPLA Country)	CE (State or Foreign	
P		146-16-5771	1X M 2 F	7	2 YRS.				Ju:	ly 13,	1923		nerlands	
3 should	α l	9e. FACILITY NAME (If not institution, give s		9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN										
2,	СТОВ	8 Charen Court Potomac Montgomery								ry				
sabes	DIREC	10e. STATE 10b. COUNT			10c. Cl						, INSIDE CITY LIMITS?			
permit. Pages 1,		Maryland Mont						Potomac 1 Tres						
usit	FUNERAL	8 Charen Court		101. ZIP COD				20854	10g. CITIZEN OF					
215-0020 attending physician. ise as the burial-transit	5	11. MARITAL STATUS	12. WAS DECEDENT	12. WAS DECEDENT EVER IN U.S. ARMED 13. W			13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No -					ited States 14. RACE — American Indian, Black, White, etc.		
21215-0020 al or attending physic for use as the burial	ВУБ	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1/ YES 2 NO					ecify Cuben, Me 2 NO Sp		to Ricen, etc.)		Black, White, etc. Specify:		
r attendir	60	16. DECEDENT'S EDU	CATION	W II	DECEDENT'S	S USUAL OCCI	IPATIO	NA .		16b. KIND OF BU	SINESS (IND.)		ite	
21 or t		(Specify only highest grade Elementery/Secondary (0-12)	College (1-4 or 5+)		(Give kind of life. Do NOT L	work done duri	ing mos	st of working		IOU. KIND OF BU	SINESS/INDUS	sini		
AND 2- the hospital o detached for once.	COMPLET		5+		search	Mete	oro	logist		N. 0	. A. A			
YLAND 2 by the hospital be detached to at once.		17. FATHER'S NAME (First, Middle, Last)	1.1		-					st, Middle, Maiden	Sumeme)			
R to by outd by led a	BE	William Van der	Hoven		401 14 14 14			Janna		lemsen	_			
MARN retained to 5 should	2	Mary W. Van der	Hoven			e as 10		nd Number or Ru	ural Route N	umber, City or Tox	vn, State, Zip Ci	ode)		
RE, nay be page		20a. METNOD OF DISPOSITION 1 Burlel 2 Cremation 3 Ram		20b. PLACE AND DATE OF DISPOSITION (Name of DATE 29c. LOCATION — City or Town State							State			
MOI lirector		4 Donatton 5 Other (Specify)		Cine	sapeal	ce Cre	mat	cory	7.					
BALTIMORE, MARYLAND are death. Page 6 may be retained by the hospita the funeral director, page 5 should be detached val. It examiner must be notified at once.		4 Donetton 5 Dother (Specify) Chesapeake Crematory 7/19 Beltsville, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A.												
BALTIMORE, after death. Page 6 may be noval. cal examiner must be 1		Cillen	×1.	agg	P	93	3 G	Gist Av	enue	Silve	r Spri	ng, M	D 20910	
760 By within 24 hours after of pmpletely filled in by the t, cremation, or removal event, the medical		23. PART i. Enter the diseases, or eshock, or heart feliure.	complications that List only one caus	caused tha	death. Do	not antar th	a mod	da of dying,	such aa c	ardiac or reap	iratory arres	it,	Approximate interval Batween	
24 hc filled tion, o		IMMEDIATE CAUSE (Final disease or condition		70-	60			1.5					Onset and Daath	
within pletely cremat		disease or condition resulting in death) a. Due TO (OR AS A-CONSEQUENCE OF): Due TO (OR AS A-CONSEQUENCE OF):												
	z													
× 8 2 8 E	CATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CON	SEQUENCE C	PF):								
D by be by	SE S	CAUSE (Disease or injury that initiated events	c. DUE TO (OR AS A CON	SEQUENCE O	IFI:								
A - E - E I	RTIF	resulting in death) LAST	4		02002.102	. ,.						į		
S, L	S	PART COther significant condition	s contribution to d	footh but on	nt consistion	des etca con etc.						1		
> 2 - 1	CAL	PART I Other significant condition	Oliver	's AO) A A A D	in the under	Hyling	causa givan	in Part I.	24a. WAS AN PERFOI		AVA	E AUTOPSY FINDINGS LABLE PRIOR TO	
S E Si jë S	MEDIC	Nuklikeus	ine 40	ait	diso	bhe	4.0	ve j		1 TYES	X X NO	OF I	IPLETION OF CAUSE DEATH?	
N red		DID TOBACCO USE CONTI	RIBUTE TO CAL	JSE OF DI	EATH Y	ES 🗆 NO	7	UNCERT	AIN 🗆			1	YES 2 X NO	
4 ∘ = -	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)												
E VIT. SICIAN: The certificate the State I, or item	YSI	1 _ YE\$ 2 _XNO	HOSPITAL:	ER/Outpatient	3 🗆 DOA	OTHER:	Nome	5 ₹ Residen	ce 6 🗆 O	ther (Specify)				
O 등 등 등 등		27. MANNER OF OEATH 1 Natural 5 Pending	28e. DATE OF II (Month, Day		28b. TIN	JURY	WOF		28d. f	EȘCRIBE NOW I	NJURY OCCUP	RED		
After death	B	2 Accident Investigation	28e, PLACE OF	INJURY - At	hame term	M 1 TES 2 NO			201.1	281 LOCATION (Street and Number of Guild				
TTEN TTEN TOR: after	ETED	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, term, street, tectory, office City or Town, State) 28t. LOCATION (Street and Number or Rural Industrial City or Town, State)							nurar noute	Number,				
E 6 5 5	PLE	29e. CERTIFIER (Check only	CIAN: To the best of n	ny knowledge,	death occurr	red at the time.	, deta	and place, and	due to the	cause(e) end me	nner ee atated.			
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	COMPL	one) 2 MEDICAL EXAMINE	R: On the beals of exa	minetion end/	or investigation	on, in my opini	lon, de	eath occured st	the time, d	ste end place, er	nd due to the c	euse(e) end	menner ee stated.	
TO THE HOSPIT TO THE FUNERA De filed within 7	BE	296. SIGNATURE AND TITLE OF CERTIFIER	C /	7)		29c. UCENSE	NUMBER	GA	29d. DATE S	IGNED (Mon	th, Day, Year)	
E E S W	5	30. NAME AND ADDRESS OF PERSON WHI	10000	en	ec)		DO	76	10	Jul	y 18,	1995	
		JUSCAL /	1. Lan	E OF DEATH (I	LU D		ŏ,	Nockle	deo	Ov E	selle di	MID	21818	
		31. DATE FILED (Month, Qay, Year)	62 REGISTRAR	SIGNATURE	Edall	3 (1	-	C(CC)	UYK	VV . D	40740	W.V.	2001/	
		JUL 19 1995	Jana and	material a state										



TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an area of the floate of may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -

HEGISTRAR	CERTIFICA	TE OF DEATH	REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)	Vollag	64	2. DATE OF OEATH	YEAR 3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In 29 04 1953 1 - M 2 X F 36		DER YEAR IF UNDER 24 HRS. B V DAYS HOURS MIN.	7. DATE OF BIFTER (Month, Day, Year) 959	B. BIRTHPLACE (State or Foreign Country)
98. FACILITY NAME (If not institution, give street and number) 4208 Edmo 4 Toh Road		adens burs	ATH 9c. co	GEOFGE'S
RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	I so city rous	N OR LOCATION		
MD R. George's	Blad	iens burg		10d. INSIDE CITY LIMITS? 1 TES 2 NO
4208 Edmonston Rd		101. ZIP CODE 207/	0	ITIZEN OF WHAT COUNTRY?
11. MARNITAL STATUS 1 Never Married 2 D Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 4NO	3. WAS DECENDENT OF HISPAN II yes, specify Cuban, Maxicar 1 YES 2 1 NO Specify		14. RACE — American Indian, Black, White, atc. Specify: BIACK
(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Give kind of work do life. Do NOT use retired	ne during most of working d.)	Legal Reserve	arch d
17. FATHER'S NAME (First, Middle, Last)	LLEZIGEN			utiek
Willie Ligget		Shil	NE (First, Middle, Malden Surname)	
Pierre VAlladay	Same	(Street and Number or Rural R	loute Number, City or Town, State, 2	Zip Code)
1 Burlet 2 M Cremation 3 Removal From State 4 Donation 5 Other (Specify)	LACE AND DATE OF DISP ery, crematory or other place Tropolitati		PLATE 200 LOCATION -	City or Town, Stata
21. SIGNATURE OF FUNERAL SERVICE LICENSEE	J	2. NAME AND ADDRESS OF FAC	814 Franklin Stre Alexandria, VA 2	
23. PART I. Enter the diseasea, pr complicatione that caused a shock, pr heert fellure. List pnly one cause on each shock, pr heert fellure. List pnly one cause of each shock, pr heert fellure. List pnly one cause of each shock, pr heert fellure. List pnly one cause of each shock, pr heert fellure. List pnly one cause one each shock, pr heert fellure. List pnly one cause of each shock, pr heert fellu	CONSEQUENCE OF):			Approximate Interval Between Onset end Death
PART II. Other eignificant conditions contributing to deeth but	not resulting in the	underlying cause given in i	Part I. 24a. WAS AN AUTOPSY PERFORMED?	AVAILABLE PRIOR TO
			1 YES 2	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH YES	NO UNCERTAIN		
EXAMINER? HOSPITAL:	. PLACE OF DEATH (Che			
1 ES 2 NO 1 Inpetient 2 ER/Outpet	lant 3 DOA 4 DA	ursing Home 5 Desidence		
27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2. NO	28d. DESCRIBE HOW INJURY OF	ose/headwindow
3 Suicide 6 Could not be 4 Homicide determined 200. PLACE OF INJURY - 4 Suiciding, atc. (Specify	OF.	- DI DI	281. LOCATION (Street and Number City or Town, State)	Geo MD
29a. CERTIFIER (Check only one) 1 CEBRIFYING PHYSICIAN: To the best of my knowled one) MEDICAL EXAMINER: On the basis of examination at				
SUL SIGNATURE AND TITLE OF CENTRIES DAVING WAS TO	0	D21230	BER 29d. DA	TE SIGNED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CALIFE OF DEAT AUGUSTO P. ROGLIGUEZ M.D. 500	H (ITEM 27) (Type, Print) 9 Rayburn	Ct., Camp Spr	rings, MD 2074	8
31. DATE FILED (Month, Day, Year) JUL 19 1995				

YEAR

9c. COUNTY OF DEATH

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

10d. INSIDE CITY

14. RACE — American Indian,

1 YES 2 NO

White

Approximate Intervel Between

Zyn

LA EL

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO

1 TYES 2 NO

29d, DATE SIGNEO (Month, Day, Year)

DO 8470

10400-CONNECTICUT AVE

COMPLETION DF CAUSE OF DEATH?

Onset and Death

Louisiana

Montgomery

10g. CITIZEN OF WHAT COUNTRY?

United States

7:25A

REG. NO

2. DATE OF DEATH MONTH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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Maria Z. Wirth July 15, 1995 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year, 8. AGE (In yrs. last birthday) IF UNDER 24 HRS. 1 M 2 F DAYS HOURS 350-28-4025 85 YRS. Mar.16,1910 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 9515 E. Bexhill Drive Kensington Pages 1, 2, RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Montgomery Kensington permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 9515 E. Bexhill Drive use as the bunial-transit 20895 hours after death, Page 6 may be retained by the hospital or attending physician. ed in by the funeral director, page 5 should be detached for use as the burial-tran 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ▼ NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexican, Puerto Ricen, atc.)
1 YES 2 NO Specify: FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 X Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) Montgomery County 5+ Public Schools School Principal once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Vito Zichichi Maria Brizolary BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Harold E. Wirth 9515 E. Bexhill Drive, Kensington, MD 20895 å 20e, METHOD OF DISPOSITION
1 🔀 Burlat 2 🗆 Cremetion 3 🗆 Removal from State 20b. PLACE AND DATE OF DISPOSITION / Name of cametery, crematory or other place) July 20, 1995 St. Louis Cemetery #3 20c. LOCATION - City or Town, State must 4 Donation 5 Other (Specify) New Orleans, Louisiana examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave., Bethesda, MD 20814-3501 filled in by the figon, or removal. M00348 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feliure. List only one cause on each line. IMMEDIATE CAUSE (Final cremation, the disease D/ condition Cerebral completely resulting in death) event. executed with OUE TO (OR AS A CONSEQUENCE OF) and com burial, CERTIFICATION traumatic Enthurl Sequentially list conditions, DUE TO (QR AS A CONSEQUENCE OF) attending physician a intal Hygiene prior to If any, leading to immediate cause. Enter UNDERLYING 2 certificate CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 death c signed by the atter Health and Mental Injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. the MEDICAL 24a. WAS AN AUTOPSY that 1 PERFORMED? any Dereto requires shows 10 certificate has been DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: * Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem State HOSPITAL: **EXAMINER?** 1 TES 2 NO OTHER PHYSICIAN: 1 - Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 Residence 8 ☐ Other (Specify) the 28e. DATE QF INJURY (Month, Day, Year) 27. MANNER OF DEATH with t 28b. TIME QF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked Natural Accident 1 YES 2 NO BY After Investigation ATTENDING DIRECTOR: Af hours after de item 28 is r 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 6 4 Homicide TO THE HOSPITAL DR ATT TO THE FUNERAL DIRECTS DE filed within 72 hours at IMPORTANT: If Item 2 COMPLET 29e. CERTIFIER
(Check only one)

1 🐰 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(e) and menner ee attated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and menner es stated. 29b. SIGNATURE AND TITLE OF CERTIF 29c. LICENSE NUMBER BE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D.

32, REGISTRAR'S SIGNATURE

Davidson Rardall

LIBRE

7 1995

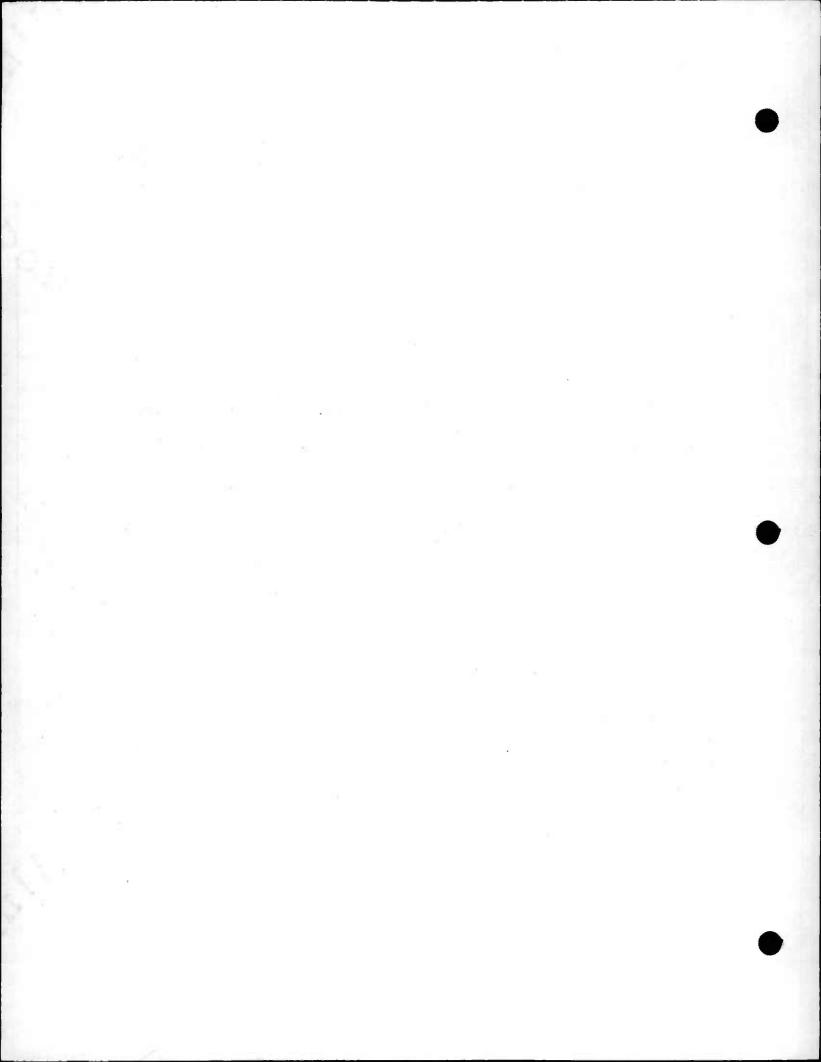
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



9

EUGENE P

31. DATE FILED (Month, Day, Year)

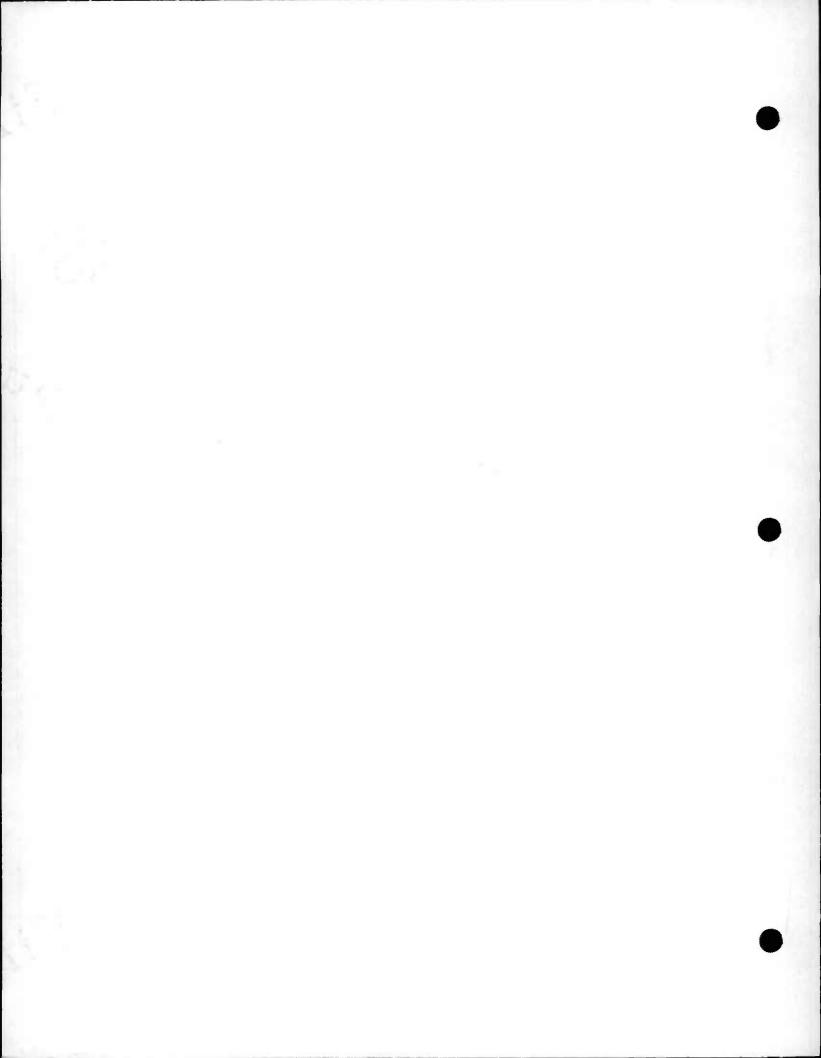


OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

	l .	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY YEAR	3. TIME OF DEATH
			NMN)	WIN	THROP		July 16		12:17 P
		4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	S. BIRT	THPLACE (State or Foreign ntry)
9	1	117-05-3885		79 YRS.	MONTHS DAYS	HOURS MIN.	Aug. 3,1		w York
3 should	_	9e. FACILITY NAME (If not institution, give	street end number)		9b. CITY, TOWN	OR LOCATION OF DE		9c. COUNTY OF	
2	DIRECTOR	Manor Care			Silver	Spring		Montgo	mery
	[RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT	Υ	Ma CITY	TOWN OR LOCA	TION			
permit. Pages 1,	E								10d. INSIDE CITY LIMITS?
THE STATE OF THE S		Maryland Mon	ntgomery	1 211/	ver Spr	Ing		1	1X YES 2 NO
	A A	2501 Musgrove Roa	1		J.				WHAT COUNTRY?
15-0020 ending physician. as the burial-transit	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER I	IN II S ADMED	12 344 0 05	20904		U.S.A	
D20 physic buria		1 Never Merried 2 Merried	FORCES? 1 YES	2 X NO	It yes, s	pecify Cuben, Maxica		Blac	CE — American Indian, ck, White, etc.
215-0020 attending physician. se as the burial-trar	BY	3 Widowed 4 Divorced	IF TES, GIVE WAN ON O	PATES	1 [] YE	S 2 X NO Specify	<i>/:</i>	wh:	ite
1215 r atten use as	ETED	15. DECEDENT'S EDU (Specify only highest grade		16e. DECEOENT'S U	ISUAL OCCUPAT	ION	16b. KIND OF BU	USINESS/INOUSTRY	LCC
21 F or 10	E	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	ork done during m retired.)	nost of working			
D spits	J d		2	Dep't. c	of Agri	culture	U.S.	Governmen	nt.
AND 2. the hospital or detached for once.	COMPL	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maider		
Z 2 2 1	III	Harry Weintraub				Clara	Ida Bass		
MARYLAND 21215-0020 retained by the hospital or attending physic should be detached for use as the burial notified at once.	8	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADORESS (Street		Route Number, City or Tox	wn, State, Zip Code)	
6 5 5 E		Edward Love		4816 M	loorlan	d Lane, B	ethesda, 1	Md. 20814	í.
ALTIMORE, death. Page 6 may be fruneral director, page	1 1	20a. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☐ Xremetion 3 ☐ Rem	200	D. PLACE AND DATE OF	F DISPOSITION /A			OCATION — City or 1	
ALTIMOR leath. Page 6 ma funeral director, p		4 Donation 5 Other (Specify)		metery, crematory or other letropolit	erplace) an Crei	matory	7/17 1	exandria.	Va
Pag al dis		21. SIGNATURE OF FUNERAL SERVICE LA	CENSEE //			AND ADDRESS OF FA	CILITY	skangria.	Vd.
fune fune		> Spant	Nadlak				eral Home		
BALTIMORE, sr after death. Page 6 may be 1 by the funeral director, page removal.		707771	se vog		2222	Wisconsi	n Ave. NW	Washing	gton, DC 2000
urs in the		23. PART i. Enter the diseases, pr shock, or heert fellure.	List only one ceuse on e	d the daath, DD no each line.	ot enter tha m	oda of dying, sucl	n as cerdiac or resp	iratory arrest,	Approximata interval Between
		iMMEDIATE CAUSE (Finei diseese or condition							Onset and Death
tely mati		resulting in death)		lmonary a					sudden
68760 ecuted with nd complete burial, crem				A CONSEQUENCE OF)					
executed and come or burial, mattic ex	8	Sequentially list conditions,		ory failu					sudden
SOX 68 ate be execut hysician and o prior to buri	Ě	if sny, leeding to immediata cause. Enter UNDERLYING		A CONSEQUENCE OF):					
D # F -	RTIFICATION	CAUSE (Disease or injury		ic carcin					1 month
certifica ding phy lygiene	E	that initiated events resulting in death) LAST		carcinoma					1
			d. Ovalian	Calcinoma					1 month
그 음 요 ? 글		PART ii. Other significant condition		out not resulting in	the underlyin	ng ceuse given in	Part i. 24s. WAS AP		b. WERE AUTOPSY FINDINGS
工 背 中 市 🛌	MEDICAL	anemia of chron	ic disease				PERFO	200	AVAILABLE PRIDE TO COMPLETION OF CAUSE
requires the seen signed of Health shows and s	I III	diabetes mellit	110				_	, Wuo	OF DEATH?
		DID TOBACCO USE CONT	RIBUTE TO CAUSE O	OF DEATH YES	Пиов	UNCERTAIN			1 123 2 NO
OR ATTENDING PHYSICIAN: The law OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has brours after death with the State Dept tem 28 is marked, or litem 23	PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF OEATH					
SICIAN: The certificate the the State d, or Item	Sic	EXAMINER? 1 YES 2 X NO	HOSPITAL: 1 Inpatient 2 ER/Outp		OTHER:	me 5 🗆 Realdence	8 Other (Specify)		
HYSICIA his certif with the	Ť	27. MANNER OF OEATH	28e. DATE OF INJURY	28b. TIME	OF 28c. IN	JURY AT	28d. DESCRIBE HOW	INJURY OCCURED	
NG PHYS ther this coath with marked,	ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUI		ORK? YES 2 NO			
OINISTON OR ATTENDING DIRECTOR: After hours after death item 28 is mai	8 0	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY	/ — At home, term, str	reet, factory, offic	ce	281, LOCATION (Street	and Number or Rural	Route Number.
TTEN TOR: after	ш	4 Homicide determined	building, atc. (Spec	cify)			City or Town, State)	,
OR ATTEND DIRECTOR: / hours after of	"	29e. CERTIFIER	01111						
1 2 3 E	₩ B		CIAN: To the best of my know						
TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 he	COMPLET		R: On the besia of examinatio	enwor investigation,	, my opinion,	uvern occured at the	ume, data end place, er	na due to the ceuse(s) and manner as stated.
THE P	띪	296. SIGNATURE AND TITLE OF CERTIFIED	8			29c. LICENSE NUM	BER		0 (Month, Day, Year)
2 6 3 ₹	2	1 yuna				D32332		July	17,1995
	-	30. NAME AND ADDRESS OF PERSON WH							
		Suresh Kumar Gup			#2-20,	Silver	Springs,MI	20902-5	288
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN						
		JUI 18 199	5 Julia davel	un wordally					

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



	ages		
physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page		
hospital or attending	stached for use as the		nce.
may be retained by th	r, page 5 should be d		st be notified at o
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician.	by the funeral director	removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
executed within 24 hou	and completely filled in	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	natic event, the me
e death certificate be	he attending physician	Mental Hygiene prior to	jury, or other traun
he law requires that th	has been signed by t	e Dept. of Health and	n 23 shows any in
ENDING PHYSICIAN: T	R: After this certificate	er death with the State	is marked, or ite
HE HOSPITAL OR ATT	HE FUNERAL DIRECTO	ed within 72 hours aft	ORTANT: It item 28
10	10.1	De fil	¥.

95 23455 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1995 Mary July 7:28 P M Η. Wells 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR | IF UNDER 24 HRS 77 DAYS 215-07-4246 1 🗌 M 2 💢 F HOURS Jan. 28, 1918 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Holy Cross Hospital Silver Spring Montgomery RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Silver Spring Montgomery 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8603 Cedar Street 20910 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 (∑NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Married If yes, specify Cuban, Maxican, Puerto Ri-1 YES 2 X NO Specify: ΒY 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 9 Sales Associate Retail 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John Hettenhouser BE Edith McCusker 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ronald Douglas Wells 6529 Garden Grove Way, Latonsville, MD 20882 20a. METHOO OF OISPOSITION
1 Carrier 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF OISPOSITION (Name of 20c. LOCATION - Cify or Town, State DATE cametery crematory or other place)
Gate of Heaven Cemetery 7/17/95 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. SIGNATURE OF FUNERAL SERVICIALICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. Approximata **IMMEDIATE CAUSE (Final** Onset and Death disease or condition ventrule tachy archiz resulting in death) DUE TO (OR AS A CONSEQUENCE OF): restive heart for DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, if any, leading to immediata cause. Entar UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): Serve CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 19-10 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO WUNCERTAIN I PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL

26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Residence 8 □ Other (Specify) 1 YES 2 NO

Inpetient 2 - ER/Outpetient 3 - DOA 28a. DATE OF INJURY 28b. TIME OF INJURY

28c. INJURY AT WORK? 1 YES 2 NO 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)

28d. DESCRIBE HOW INJURY OCCURED

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

MD 20902

29a. CERTIFIER (Check only	1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piaca, and due to the cause(s) and manner as stated.
one)	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the co

				a to this cause(a) and in	Markiner and menti
ATURE AND TITLS OF CERTIFIER		29c. LICENSE NUMBER	290	DATE SIGNED (Month	One Monet

ì	pule	1/		ch									
30.	NAME AND	ADDRESS	OF PER	SON WHO	COMP	LETED	CAUSE	OF	DEATH	(ITEM	27)	(Type.	Print

10313 Geografice

18 1995 REGISTRAR'S SIGNATURE

Investigation

determined

8 Could not be

Michael Lincoln Mo

27. MANNER OF CEATH

1 Natural

2 Accident

3 Sulcide

290, 510

4 Homicide

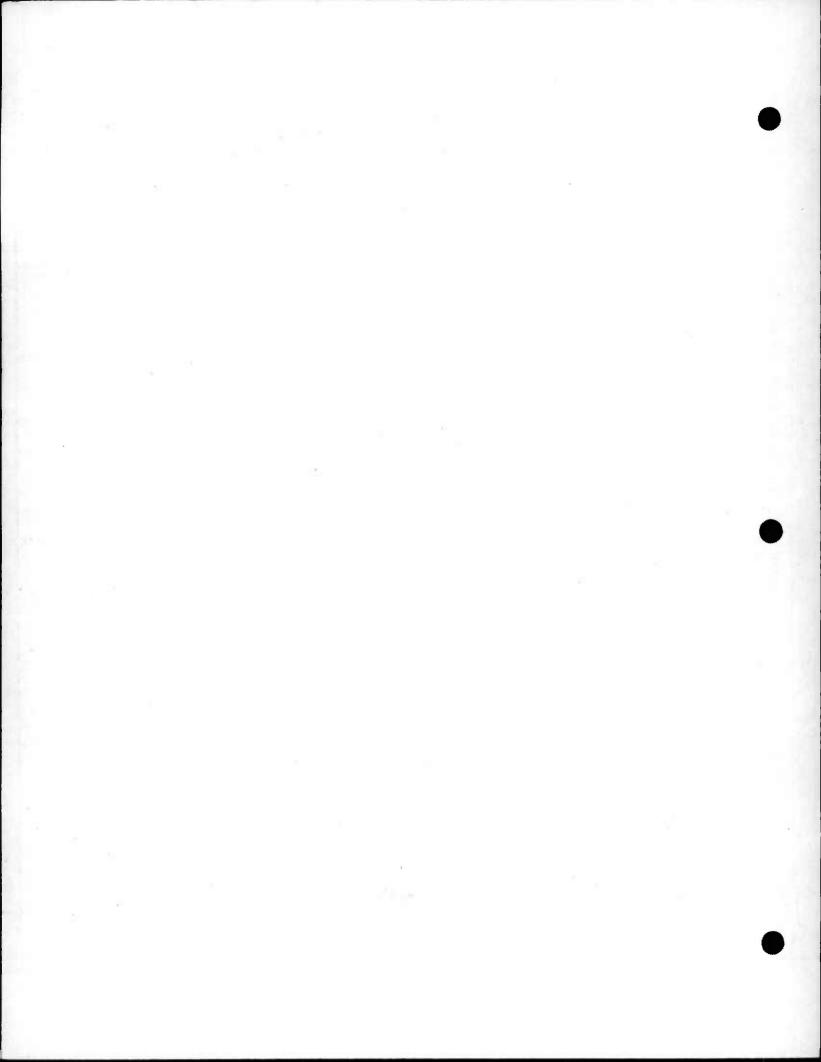
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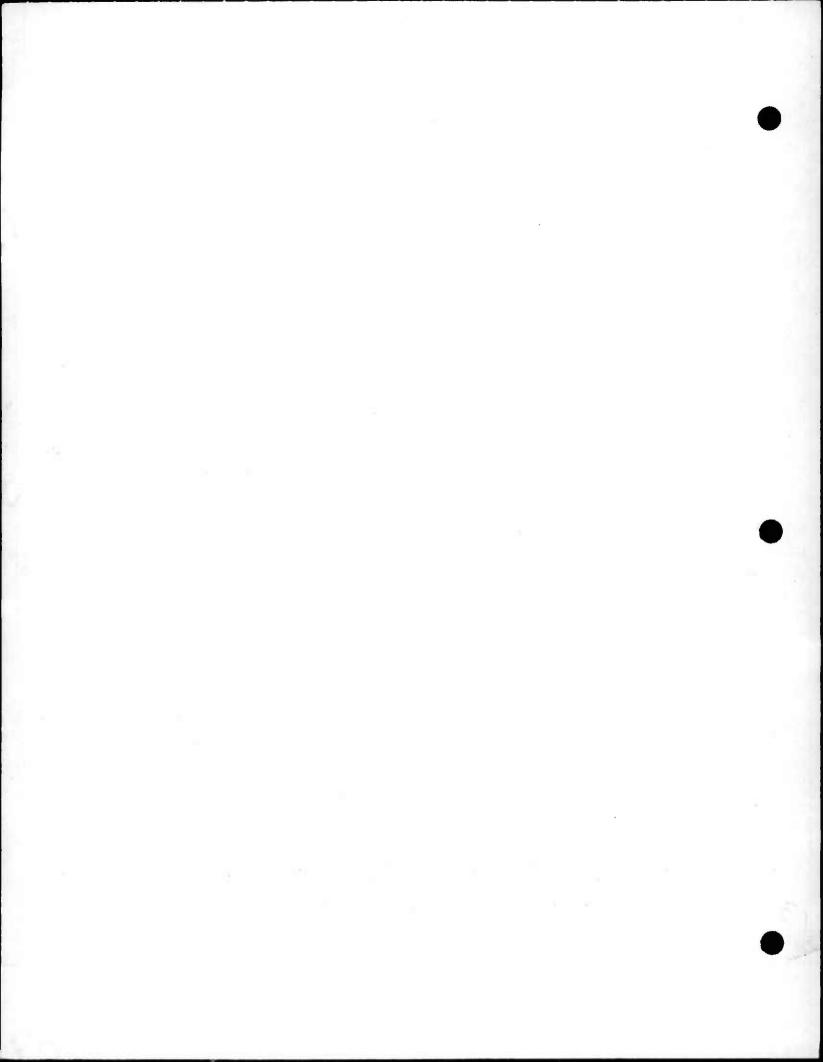
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DHMH-16 Rev 1/89



		FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMENT OF I	HEALTH AND	MENTAL HYGI		7900			
		1. DECEDENT'S NAME (First, Middle, Last)	l 1	11: -mama			2. DATE OF DEATH	N DAY	YEAR	TIME OF DEA	ATN	
		4. SOCIAL SECURITY NUMBER		Wigmore (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	July 18	, 1995		7:30 CE (State or F	Ам	
pin	1	213-58-9219	1 🔀 M 2 🗆 F	42 YRS.	MONTHS DAYS	HOURS MIH.	Dec. 29,	" 1952 s	Country)	Afric		
2, 3 should	TOR	90. FACILITY NAME (If not institution, give at 440 Palmspring DY RESIDENCE OF DECEDENT				or Location of Di ersburg	EATN	9c. COUNT	gomer	N		
ges 1,	DIRECTOR	10a. STATE 10b. COUNT	Y	10c. CII	TY, TOWN OR LOCA	TION				I. INSIDE CIT	ry	
permit, Pages 1,		Maryland Mont	tgomery	Ga	aithersb	Urg M. ZIP CODE		I sale assess	1)	LIMITS?) NO	
tis.	FUNERAL	440 Palmspring Dr	rive			20878		100		country? States		
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit notified at once.	ΒY	11. MARITAL STATUS 1. Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 X YES	2 NO	If yee, ap	CENDENT OF NISPAI	NIC ORIGIN? (Specify an, Puerto Rican, etc. fy:	Yee or No- 1	I4. RACE — A Black, WI Specify:	American ind hite, atc.		
215 attend use as	TED	15. DECEDENT'S EDU (Specify only highest grade	ICATION	16a. DECEDENT'S	S USUAL OCCUPATION		16b. KIND OF	BUSINESS/INDUS	<u>Whi</u> stay	.ce		
AND 21215-0 the hospital or attending detached for use as the once.	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	use retired.)] ,, ,	A : F				
YLAND Spital by the hospital be detached to at once.	COMPL	17. FATNER'S NAME (First, Middle, Last)		20arr	Sergeant		U. S.	Air Fo	rce			
d by th	BE C	Alfred A. Wigmon	re, Sr.				ret M. Hy	· ·				
MAR retained 5 should	0	19a. INFORMANT'S NAME (Type/Print)	777			end Number or Rural i	Route Number, City or	Town, State, Zip Co		2000		
bage bage		Alfred A. Wigmon	201	LU510			Silver S					
0 0		1X Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	noval from State CBN	metery, crematory or o	other place)			LOCATION — CIL Arlingt			nia	
		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	Langue.	22. NAME A	ND ADDRESS OF FA	ICILITY			11 911	14	
		Cllen	W. Ka	pp	933 (Gist Aver	Services nue, Silv	er Spri	ing, M	1D 209	10	
24 hours aft filled in by tion, or remother		23. PART I. Entar tha diseases, proshock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on e	each line.				spiratory arres	it,	Approxim Interval B Onset and	Between	
, P.O. BOX 688 and certificate be execute attending physician and control to buniary, or other traumatic.	CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Meta/fa/fa/cc/com/dro/cercem/a Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
= 2 = =	- 11	PART II. Other significant condition	is contributing to death b	out not resulting	in the underlying	g cause given in	Part I. 24a, WAS	AN AUTOPSY FORMED?		RE AUTOPSY F		
O 5 8 - 8	MEDICAL						1	S 2 NO	CON	APLETION OF O		
9 5 5		DID TOBACCO USE CONTR	DIRLITE TO CALISE O	NE DEATH VI		UNCERTAIN			1 [YES 2 X	NO	
The law te has the Dept of the	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEAT			<u>ч</u> П					
CIAN: Th prifficate he State or item	YSIC	1 TES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outp	patient 3 🗆 DOA	OTHER: 4 - Nursing Nom	ne 5X Residence	6 Other (Specify)					
NG PHYSIC feer this ce eath with the marked,		27. MANNER OF DEATN 1 X Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	26b. TIM INJ	JURY WO	DRK?	28d. DEŞCRIBE NO	W INJURY OCCU	RED			
NOING P Hearth Is mar	ВУ	2 Accident Investigation	26e. PLACE OF INJURY	— At home, term,		YES 2 NO	281. LOCATION (Stre	net and Number or	- Rurel Route	Number		
OR ATTENDING PHYSICIAN: The ORECTOR: After this certificate his nours after death with the State of them 28 is marked, or item	IE	4 Nomicide 6 Could not be determined	building, etc. (Spec	Hy)			City or Town, St	ete)	Florer i nanco	Warnings,		
4 4 Z	COMPLETED		ICIAN: To the best of my knowl							menner ee i	hateta	
TO THE HOSPITAL TO THE FUNERAL De filed within 72 I	20	29b. SIGNATURE AND TITLE OF CONTURE				29c. LICENSE NUM	/			nth, Day, Year)		
THE CE THE PO THE	TO BE	Robert & Chi	dow			MD 049				1995		
	-	30. NAME AND ADDRESS OF PERSON WIN	o completed cause of deal	ATN (ITEM 27) (Type,	/) 0023	5 16th S	Street, N DC 2030	W	·, ,			
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA				20 2000	, 000.2				



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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or att	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use	be find within 22 nours arter deam with the State Dept. or Healm and Merita Hydrere prior to burla, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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/	7	mended#1 1 - STATE REGISTRAR	STATE OF MAR	195- IYLAND / CI	/Y) DEPAR ERTIF	RT ITMENT O	Monto	MENTAL HYGIE	Co.	25,	£3457		
	i	1. DECEDENT'S NAME (First, Middle, Last) GARY W WELTE	Gary					2. DATE OF DEATH MONTH JULY 16		YEAR	3. TIME OF DEATH		
		4. SOCIAL SECURITY NUMBER	-/	VGE (In yrs. las		IF UNDER 1 Y		7. DATE OF BIRTH	, 199	_	8:00p m M		
	l	218-66-8145	1)(X M 2 □ F	38	YRS.	MONTHS DA	NYS HOURS MIN.	(Month, Day, Year)	1956	Count	aryland		
	.	9a. FACILITY NAME (If not institution, give str	reet and number)			96. CITY, TO	WN OR LOCATION OF						
Ę		DOCTORS COMMUN	<u>ITY HOSPI</u>	TAL		LANHA	M-SEABROO	K	PRI	NCE (GEORGE'S CO.		
DIRECTOR		10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR L	OCATION				10d. INSIDE CITY		
		4	ce George'	S	Bow	ie				4 _1	LIMITS?		
FUNERAL		100. STREET AND NUMBER	o Court				10f. ZIP CODE		1		WHAT COUNTRY?		
l E		2112 Princess Ann	12. WAS DECEDENT EVI	ER IN U.S. AR	RMED	13. WM.S	20716	PANIC ORIGIN? (Specify			States		
À		1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 10 V IF YES, GIVE WAR O 1977-1985	PROATES	NO	If ye	s, specify Cuban, Max YES 2 NO Spe	Ican, Puerto Rican, etc.)	or NO	Spec	E — American Indian, k, White, atc. //y: //hite		
		15. DECEDENT'S EDUC (Specify only highest grade of	ATION completed)	(G	ive kind of v	USUAL OCCU	PATION ig most of working	16b, KIND OF B	USINESS/IN		10		
COMPLETED		Elementary/Secondary (0-12) College (1-4 or 5+) Armed Guard Painko											
NO		1 Armed Guard Brinks 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maidlen Surname)											
BEC													
0		19a. INFORMANT'S NAME (Type/Print)		198	_			al Route Number, City or To	own, State, Z	(p Code)			
		Wilfred A. Peters 20a. METHOD OF DISPOSITION	on, Jr.	2 h2 +0 1 7 2	-	ne as							
		1 Buriel 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val from State	cometery, cre	metory or o	ther plece)			OCATION -				
	ľ	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	Ulles	apeai	22. NAN	Matory IE AND ADDRESS OF	FACILITY			Maryland		
		· Edein	W. Ka	RP	j	933	Gist Ave	Services, nue, Silve	r Spr	ing,	MD 20910		
		23. PART I. Enter the diseases, or co shock, or heart feilure. L	omplications that cause o	sed the de	sth. Do r	not enter the	mode of dying, so	uch as cerdiec or res	piratory as	rest,	Approximete interval Between		
	1	IMMEDIATE CAUSE (Finel disease or condition		A		Lo	Pre	dist.	٥.		Onset and Death		
		resulting in deeth)	DUE TO (OR /	AS A CONSEC	DUENCE OF	,	CAIL	01111	<u> </u>		Sorbe		
z	ļ	C .		TRKI	v.	151	AD	5			2 mours		
ATION		Sequentially list conditions, if any, leading to immediate	DUE TO (OR A	AS A CONSEC	DUENCE OF	F):							
10	- 10	CAUSE (Disease or injury	DUE TO (OR A	AS A CONSEC	DIJENCE OF	n.							
CERTIFI		that initiated events resulting in deeth) LAST			JOE 110E 01	,							
		PART ii. Other significant conditions	contributing to deet	th but not r	esulting I	n the under	lying ceuse given	In Part i. 24a. WAS A	N AUTOPSY	24b.	. WERE AUTOPSY FINDINGS		
S									ORMED?		AMILABLE PRIOR TO COMPLETION OF CAUSE		
MEC									- Miles		DF DEATH? 1 YES 2 NO		
Z		DID TOBACCO USE CONTR	IBUTE TO CAUSE					IN 🗆					
PHYSICIAN: MEDICAL			HOSPITAL:			OTHER:							
HXS		1 TYES 2 NO	1 Nipetient 2 ER/		DOA 28b. TIM		Home 5 Residence	8 Other (Specify) 28d. DESCRIBE HOW	IN IT IS YOU	CUREO			
ВУ Р		1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Yea	er)	INJ	URY	WORK?	244. DESCRIBE NOR	INJUNI OC	CONEO			
		3 Suicide 8 Could not be determined	28e. PLACE OF INJ building, etc. (URY — At ho Specify)	ma, farm, s	trast, factory,	office	28f. LOCATION (Stree City or Town, Stat	t and Numbe	r or Rural A	loute Number,		
COMPLETED	-	as oreview /				A 115-1							
MP		(Check only one) 2 MEDICAL EXAMINER						us to the cause(s) and m					
	-	296. SIGNATURE AND TITLE OF CERTIFIER		A state of	aiigatio	, ту орти	29c. LICENSE N						
BE.		t dard	Udal	1 m	1		LICENSE N	1947	290. DA1	T-	(Month, Day, Year)		
1 2		30 NAME AND ADDRESS OF PERSON WHO	COMPLETED OWNER OF	DCATA GTO						1	, , , , ,		

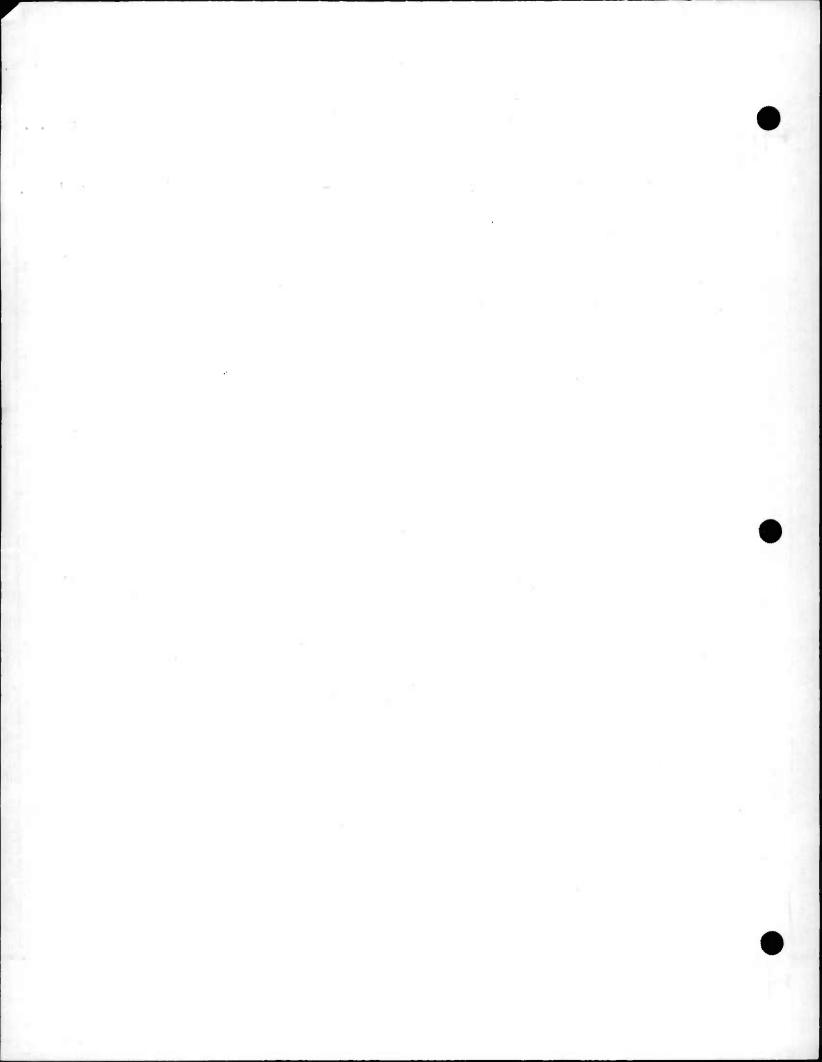
a medione examinen.	THE DESIGN OF EXAMINITATION STREET	investigation, in my opinion,	death occured at the time, day	ta and placa,	and due to the cause(a) and
SIGNATURE AND TITLE OF CERTIFIER .	1 301		29c, LICENSE NUMBER		20d DATE GIGNED (Man

PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

TO LONG Gallat

31. DATE FILED (Month, Day, Year)

JUL 19 1995



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR

One of the state of Maryland / Department of Health and Mental Hygiene CERTIFICATE OF DEATH

REG. NO.

	TIEGIOTTATI				LILIE	ICHIE	- Or	DEA	П		REG. NO),		
1	1. DECEDENT'S NAME (First	GAR	BRICK							2. DATE O	0	MY	YEAR	3. TIME OF DEATH
		-	RICK WE								Y 22	1995		8:45 PM M
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. le		MONTHS DAYS HOURS MAN				7. DATE O (Month,	F BIRTH Day, Year)		8. BIRTH Count	IPLACE (State or Foreign
	180-14-55	71	1 🗆 M 2 😾 F	84	YRS.					JULY 3, 1911 I			1 P	ENNSYLVANI
œ	9e. FACILITY NAME (If not in	200				9b. CITY	, TOWN C	R LOCATIO	ON OF DE	ATH		9c. COU	NTY OF D	EATH
DIRECTOR	SACRED H	EART F	IOSPIT/	AL		CI	IMBE	RLA	ND_			LAI.	LEG	ANY
3EC	10e. STATE	10b. COUNTY			10c, CIT	Y, TOWN C	R LOCAT	ION						10d. INSIDE CITY
	MARYLAND	ALLEG	GANY		L	A VA	LE							LIMITS?
FUNERAL	10e. STREET AND NUMBER						101	ZIP CODE				10g. CIT	IZEN OF V	WHAT COUNTRY?
E I	4 REN R	OY DRI	VE					215	02			п	SA	
٤	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. A	RMED	13.	WAS DEC	ENDENT O	F HISPAN	IIC ORIGIN?	(Specify Ye		14. RACI	E — American Indian, k. White, stc.
ВУ	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE W					2 XNO			can, etc.)		Spec	Hy:
	15 DEC	EDENT'S EDUCA	TION	T ₄₀ , 0	ECEDENT'S									WHITE
COMPLETED	(Specify only	y highest grade co	empleted)	(0	Give kind of v B. Do NOT us	vork done o	during mo	on st of workin	g	16b.	CIND OF BU	SINESS/INI	DUSTRY	
7	Elementary/Secondary (0)-12)	College (1-4 or 5 d	+)	SELF		TAV	PPD	ET (AD T C	re .		011D-	
OM	17. FATNER'S NAME (First, M	liddle, Last)	4		ELF	EHI	LUI			ME (First, Mi			OWEI	{
U U	JOHN MI	TCHELL	CARRE	TCE								,		
0	19e. INFORMANT'S NAME (7		GARDE		Db. MAILING	ADDRESS	(Street e			VINI)
2	MITCHELL	UFICH												
	20a. METNOD OF DISPOSIT	ION		20b. PLACE	AND DATE O					DATE		CATION —		
	1X Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		al from Stata	cametery, cr	ematory or of	har placa)			שתו	1				A. 1-10-0
	21. SIGNATURE OF FUNERAL	SERVICE LICEN	SEE		ELP	22.	NAME AN	D ADDRES	S OF FAC	CILITY	1+45	CIIM	RERI	AND, MD
	Dow	alas	A	Hal	(1)	H	AFE	R CI	IAPE	EL OI	THI	HI	LLS	MORTUARY
-	22 PART I Setes the di	0		1	~		302	NAT	TON	TAT E	UV	TA	VATE	
	23. PART i. Enter the di shock, or h	seases, or cor sert fellura. Lie	mplications that at only one cau	se on each lim	eath. Do n	ot anter	tha mo	da of dyi	ng, suct	h as cardi	oc or reap	iretory an	rest,	Approximata interval Batween
	iMMEDIATE CAUSE (Findisease or condition	nal	0 -		. 1			0		4)	,		Onset and Death
	immediate cause (Final disease or condition resulting in death) a. Intracronial Hammerhage & hematima Unknown Due to (or as a consequence of):													
	DUE TO (OR AS A CONSEQUENCE OF):													
CERTIFICATION	Sequantially list conditi		DUE TO	(OR AS A CONSE	OUFNCE OF	10	7							13 jeans
Ä	if any, leading to immed cause. Enter UNDERLY	NG		0										
Ħ	CAUSE (Disease or inju that initiated events	ny 1 "	DUE TO	(OR AS A CONSE	OUENCE OF	7:								
ᇤ	resulting in death) LAS	T d.												
	PART II Other clerifica	nt annettilana		Acres to a con-										
MEDICAL	PART II. Other significa	in conditions	contributing to	death but not	resulting i	n tha un	dariying	cause g	ivan in i	Part i.	PERFO		24b	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ă										-	YES 2	NO		COMPLETION OF CAUSE OF DEATH?
- 1														1 TYES 2 NO
ä	DID TOBACCO U		BUTE TO CA					UNC	ERTAIN	10				
힐	25. WAS CASE REFERRED TO EXAMINER?	ŀ	IOSPITAL:		CE OF DEAT	OTHER								
PHYSICIAN:	1 YES 2 5 NO	1	☐ Inpatient 2 3			4 🗆 Nurs	ing Hom		sidence	6 Other	Specify)			
ᆵ	to a	Pending	28e. DATE OF (Month, De	INJURY ny, Year)	28b. TIME	URY	28c. INJI WO	RK?		28d. DESC	RIBE HOW I	NJURY OC	CURED	
B	2 Accident	Investigation				М		ES 2	NO					
		Could not be	building,	F INJURY — At he atc. (Specify)	ome, farm, s	treet, facto	ory, office			28f. LOCAT	Town, State)	end Number	or Rural F	loute Number,
COMPLETED	no- occurrent													
린			N: To the best of											
ģ I	2 MEDI	CAL EXAMINER:	On the beele of ex	ramination and/or	Investigation	n, in my o	pinion, de	eth occur	ed at the	time, date a	nd plece, an	d due to th	e ceuse(s) end menner ae stated.
BE	29b. SIGNATURE AND TITLE		- // .	-			Т	29c. LICE	NSE NUM	BER		29d. DAT	E SIGNED	(Month, Day, Year)
			· Vulce					D17	7474	4		> /	7/23	FS .
2	30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH (ITE	М 27) (Туре,	Print)							,	
	DK.VI	ICENT 90	O9B SETO	JN DR. (UMBEI	KLANI), M	D. 2	1502					
	31. DATE FILED (Month, Day, 1	Year)	12 BEGISTRA	R'S SIGNATURE										
ļļ.	The same (month, buy,	Mr	/ Vm.	huchen-Ra										

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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urs after death. Page 6 may be retained by the hospital or attending phys in by the funeral director, page 5 should be detached for use as the bunit removal.	adiani avaminas must be natition at anne
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merital Hyglene prior to burial, cremation, or removal.	BEDONTALT M Same 70 to second of Seas 72 shows any lating or school religious to the second sho second

											95	23459
	FOR 1 - STATE REGISTRAR	STATE OF M			RTMENT FICATE				MENTAL HYGIEN REG. NO			
	1. OECEOENT'S NAME (First, Middle, Last)								2. DATE OF DEATH	AY	YEAR	3. TIME OF DEATH
	ETHEL MAE	WHITE									995	5:05 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les		IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRT	HPLACE (State or Foreign
	219–20–5236	1 🗌 M 2 🔀 F	84	YRS.	MONTHS	DATE	HOuns	MIN. (ct. 27, 191	0	Mar	ÿland
	9e. FACILITY NAME (If not institution, give st						OR LOCATIO			9c. CO	UNTY OF	
9	Sacred Heart Hospi	.tal			Cumb	ærla	and			A11	egan	У
[다	RESIDENCE OF DECEDENT			T 400 CIT	TY, TOWN O	2 : 004						
DIRECTOR	Maryland Allega	iny			aconi		ION					10d. INSIDE CITY LIMITS? 1 YES XX NO
A	10e. STREET AND NUMBER					101	. ZIP CODE	E		10g. Cl	TIZEN OF	WHAT COUNTRY?
띮	15407 Old Beechwo	od Rd.S.	W.			1 2	21539)		USA		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT			13.	WAS DEC	ENDENT (OF HISPAN	IIC ORIGIN? (Specify Yes	or No-	14. RAC	E — American Indian, ck, White, etc.
BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1	YES 2 TA	10		If yee, sp	ecity Cuba 2 NO	ın, Mexicei	n, Puerto Ricen, etc.)			ok, white, etc.
	15. OECEDENT'S EOUC	CATION	18e. DE	CEOENT'S	B USUAL OC	CCUPATIO	ON		16b. KIND OF BU	SINESS/IN	INUSTRY	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+	(Gi	ive kind of a	work done o	during mo	st of working	ng		311111007	Dogram	
1	8	College (1-4 or 5+)		istod	lian				Bank			
MO	17. FATHER'S NAME (First, Middle, Last)	0					10 MOT	HED'S NA	ME (First, Middle, Malden	Cumpma)		
		-4										
B	Lawrence Broadwa	iter	10	- MAH 100	- 4000E0	- Charact o		aida			- 11	
욘	Wilmer Whiteman		1.5	319	Old I	3eec	hwood	d Rd	SW., Lonac	onin	ig, Md	.21539
	20e. METHOD OF DISPOSITION 1. Burlel 2 Cremetion 3 Remo	- A A Canto	20b. PLACE	AND DATE	OF DISPOS	ITION (Na	me of		OATE 20c. LO	CATION ~	- City or T	own, State
	4 Donetion 5 Other (Specify)	John State	Green	Ceme	other place)		Ju	ılv 2	0,1995 Lor	nacor	ning.	Md.
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	1				ND ADDRES	SS OF FAC	CILITY	MICC.	1116	ra.
	My E. Mul	40			Ei	chho	orn-M	1cKer	nzie Funera 1. 21539	al H	ome	
	23. PART I Enter the diseases, or c	complications that	t Caused the de	ath. Do	not entar	the mo	da of dy	ing, such	h as cardiac or reapi	ratory a	rrest,	Approximate
	shock, or heert failure. I	List only one caus	se on each line	J.				-				Interval Between Onset and Deat
	diseese or condition	0,000	2000		· lina		A	200				Q COL
	resulting in death)	DUE TO	(OR AS A CONSEC	OLIENCE C	11170	<u> </u>	Re	1190				CAN
-			5.0510	20	1000	C 's	-					de la constant
ERTIFICATION	Sequentially list conditions,		(OR AS A CONSEC	OUENCE C	DF):	100	2					ON than
Ä	If any, leading to immediate cause. Enter UNDERLYING		,									
윤	CAUSE (Disease or Injury that initiated events	DUE TO	(OR AS A CONSEC	OUENCE O)F):							
E	recuiting in death) LAST											
핑		1										1
7	PARTII. Other significant condition	contributing to	death but not r	paulting	In the un	derlying	Tense (given in			248	. WERE AUTOPSY FINOINGS
MEDICAL	DEIZUR E	5NO 10	MACRE	K	WPE	-)	380	ARE	PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
밀								- N - N - N - N - N - N - N - N - N - N		A		OF DEATH?
	DID TOBACCO USE CONTR	DIRLITE TO CA	LICE OF DEA	TH V	EC []	NO E	≯ UNC	CDTA!				1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	IBOIL TO CA			TH (Check o		DIAC	EKIAN	4 []			
2	EXAMINER?	HOSPITAL:	250 AV		OTHER	3:						
ξŁ	27. MANNER OF DEATH	28e, DATE OF		28b. TIM	_			sidence	6 Other (Specify)			
	1 Netural 5 Pending	(Month, Da	ay, Ybar)		JURY		RK?		28d. DESCRIBE HOW I	NJURY O	CURED	
B	2 Accident Investigation	28- 81 405 0	T IN H III	<u> </u>			YES 2	NO				
8	3 Suicide 8 Could not be 4 Homicide determined	building,	F INJURY — At hor etc. (Specify)	me, tarm,	atreet, tacto	pry, office	ž		281. LOCATION (Street of City or Town, State)	and Numbe	er or Rural	Route Number,
<u>-</u>	29e. CERTIFIER	The state of the state of	CONTRACTOR OF THE							-		
P P	(Check only CERTIFYING PHYSIC											
COMPLET	2 MEDICAL EXAMINER	A: On the basis of ex	amination end/or i	investigation	on, in my o	pinion, d	eath occur	red at the	time, date end place, en	d due to	the cause(s) end menner ee stated.
ш	296. SIGNATURE AND TITLE OF CERTIFIER	, ,	DEN	1			29c. LICE	ENSE NUM	IBER	29d. DA	TE SIONE) (Month, Day, Year)
m	90	BOIL P	Flor	1700	. Dox	TA	T	131	273	▶ .	TIII.Y	17, 1995
유	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUS	SE OF DEATH (ITE	M 27) (Type	a. Print)	2500		000	010.		7011	17, 1775

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hours after death. Page 6 may be retained by the hospital or attending physician. page 5 should be detached for the funeral director, filled in cremation, completely Mental Hygiene prior to burial, requires that the death certificate be signed by the of Health Dept has OR ATTENDING PHYSICIAN: The the with death DIRECTOR: after hours

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1 DECEDENT'S NAME (First Middle Leat) 2. DATE OF DEATH 3. TIME OF DEATH YEAR July Jasper Joseph ALBANESE 28, 3:00 A 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday, 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Ma 1 🔀 M 2 🗌 F 068-07-8765 nsw Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give stree 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR RR Cscil 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY PARVAMO permit. I 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOF 10g, CITIZEN OF WHAT COUNTRY? use as the burial-transit OAO, .A 21014 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-il yea, specify Cuban, Mexican, Puerto Rican, atc.) 1 YES NO Specify: 11. MARITAL STATUS - American indian. White, atc. 1 Never Married 2 Merried B 3 Widowed 4 Divorced IE-CI.CU COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEOENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INQUISTRY entary/Secondary (0-12) College (1-4 or 5 +) 12485 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME /First Midd notified at MALORE BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, 21014 2 THER. pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must 4 ☐ Donation 5 ☐ Other (Specify) i Al medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MERRY 21020 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Finel **Onset and Death** traumatic event, the disease or condition_ Urosepsis 7/13/95 resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST injury, or PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 YES 2 X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO MI UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 TYES 2 X NO 1 X Inpatient 2 - ER/Outpatient 4 Nursing Home 5 Residence 8 Other (Specify) marked, or 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 X Netural 5 Pending 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, larm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) S 8 Could not be COMPLETED 28 4 Homicide Hem 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(a) and manner as stated. TO THE FUNERAL D
be filed within 72 h
IMPORTANT: If II 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 7/28/95 D32395 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THOMAS FINUCAN, VAMC PERRY POINT, PERRY POINT, MD 21902

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DIVISION OF VITAL	

Pages 1, 2, 3 should permit. signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Health and Mental Hygiene prior to burial, cremation, or removal. or attending physician. the hospital notified at Page 6 may be retained by Pe must examiner hours after death. cremation, or removal medicai event, the traumatic other injury, or requires that the shows any peen 50 23 has this certificate h with the State I OR ATTENDING PHYSICIAN: 6 marked, DIRECTOR: After the hours after death v 4 28 Hem TO THE FUNERAL D
TO THE FUNERAL D
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IMPORTANT: If its

CERTIFICATION

MEDICAL

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95 23461 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Ilen 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday 7. DATE OF BIRTH IF UNDER 1 YEAR IF LINDER 24 MRS. Sa. FACILITY NAME (If not institution 9b. CITY, TOWH OR LOCATION OF DEATH 9c. COUNTY OF DIRECTOR RESIDENCE OF 10b. COUNTY 10d. INSIDE CITY 10c, CITY, TOWN OR LOCATION 1 YES 2 NO FUNERAL 10e. STREET AND NUMBE 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9 P 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-it yes, specify Cuban, Maxican, Puerto Rican, atc.) RACE — American Indian, Black, White, atc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 1 YES 2 W NO Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest gi e (1-4 or 5+) ntary/Secondary (0-12) 0 0 17, FATHER'S NAME (First, Middle, Last) BE 19a, tNFORMANT/S NAME (Type/Print) 19b. MAILINO AOORESS 2 0 METHOD OF DISPOSITION 206 PLACE AND DATE OF DISPOSITION (Name of DATE 1 Burial 2 Cremation 3 Red 4 Donation 5 Other (Specify) 8 21. SIGNATURE-OF FUNERAL SERVICE LIGHNSEE 22. NAME AND ADDRESS OF FACILITY Sep Jo 23. PART I. Shier the diseases, or complications that ceused the death. Do not enter the mode of dying, auch as cardiac or respiretory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) Cardiomyopathy PUE TO (OR AS A CONSEQUENCE tension Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? 1 TYES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) ROSPITAL:
1 | Impatiant 2 | ER/Outpatient OTHER: 1 YES 2 NO DOA 4 Nursing Home 5 Realdence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 5 Pending Investigation 1 Natural М 1 YES 2 NO Accident 28e. PLACE OF INJURY — At home, term, street, tactory, office building, etc. (Specify)

29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as atated. (Check only one) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year)

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, 2 1995 0

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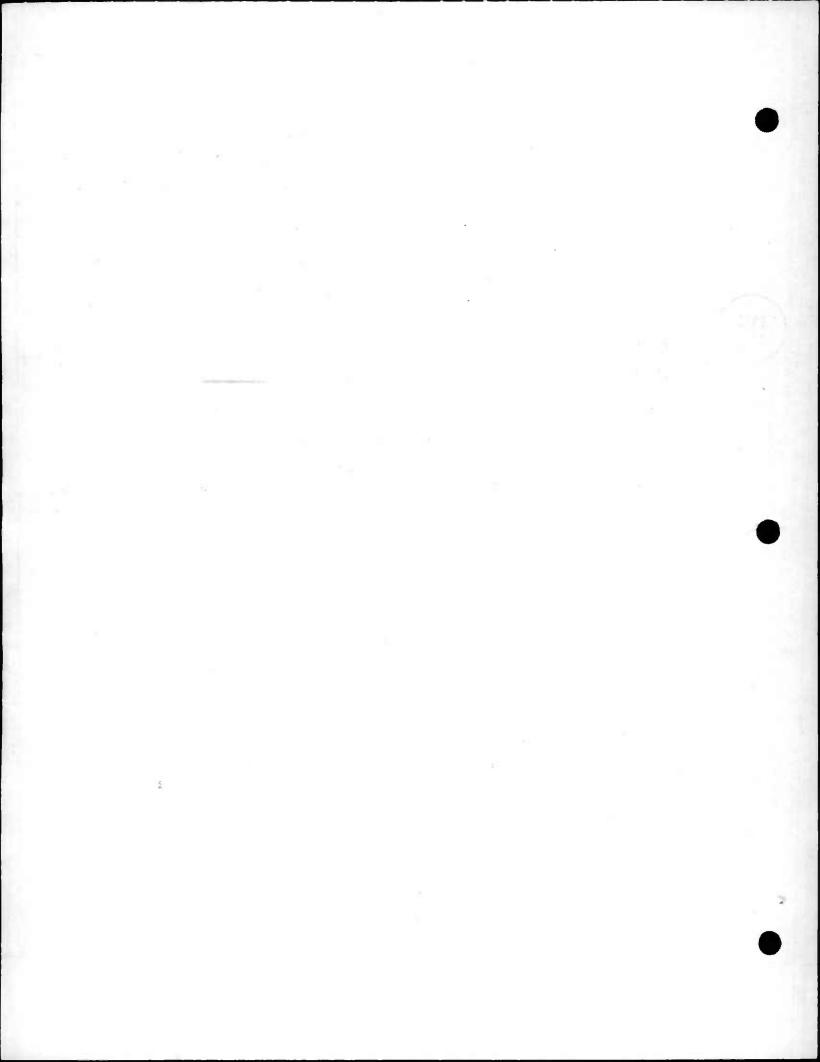
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28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)

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1	-	FOR STATE REGISTRAR			STATE	0F	M
		Item18,	9-726,	8-2-95	perf.	h.	, d

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	BEG NO

	1. DECEDENT'S NAME (FIRST,		CAI	viN	{	Brev	ver			2. DATE OF MONTH	DA		YEAR 95	3. TIME OF OEATN 3:16 A M
	4. SOCIAL SECURITY NUMBER 216-07-0662 5. SEX 6. AGE (In yrs. last 1×10^{-1} M $_2 \times 10^{-1}$ F 76				VRS.	MONTHS DAVE MONTHS AND		24 HRS. MIN.	7. DATE OF BIRTN (Month, Day, Year) JAN. 28, 1919		8. BIRTNPLACE (State or Foreign Country) MARYLAND			
LOR	HARBOR HOSP	9a. FACILITY NAME (if not institution, give street and number) HARBOR HOSPITAL CENTER						ALTIM				9c. COU	NTY OF DE	
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY		- CDXZ	10c. CIT	Y, TOWN C								10d. INSIDE CITY LIMITS?
								10a. CIT	1 ⅓ YES 2 ☐ NO					
2023 WHISTLER AVENUE 21230								U.S.A.						
B	11. MARITAL STATUS 1 Never Married 2 3 XWidowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	IT.EVER IN U.S. ARI VES 2 N WAR OR DATES WAR T	RMED 13. WAS DECENOENT OF HISPANI If yee, specify Cuben, Maxican 1 ☐ YES 2 ☐ NO Specify:				n, Puerto Rican, etc.) Blac				— American Indian, , White, atc. y: WHITE	
TED	(Specify only	EDENT'S EOUC highest grade	CATION completed)	(Gi	ve kind of v	USUAL O	CCUPATIO	ON est of working	g	16b. KIN	ID OF BUS	SINESS/INC	DUSTRY	
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S	17. FATNER'S NAME (First, M BENJAMIN BR							18. MOTH		ME (First, Middle	e, Msiden :	Sumsme)	obins	
) BE	19s. INFORMANT'S NAME (7)	ype/Print)		198	, MAILING	ADDRESS	(Street a	and Number		Oute Number, (*			
٩	SANDY G. MA		A		2023	WHI	STLE	ER AV	ENUE	- BAI	TIMO	RE,	MD	21230
	20a METHOD OF DISPOSITI 1 Burisi 2 Crematio 4 Donation 5 Other	n 3 🗆 Ramo	oval from Stats	20b. PLACE A cometery, cree CROWNS	ND DATE OF	ther plece)	TER A	MC C	ГM	DATE			City or Tow	vn, Stats
	21. SIGNATURE OF TUNERIA	L SERVICE LIC	ENSEE	4	1200	22.	NAME A	ND ADDRES	S OF FAC				TULE	
_	Terris	, 1.	mill			41	07 V	VILKE	NS A	VENUE-	BAT.T	TMOR	E. MI	0 21229
	23. PART i. Enter the di shock, or he iMMEDIATE CAUSE (Fin disease or condition resulting in death)	eart failure. I lei	List only one cet Chron DUE TO	ise Dn eech line.									reat,	Approximate interval Between Onset and Death
_			_			F):								7.25.95
TION	Sequentially list conditi if any, leading to immed	Dna,	Dehy DUE TO	(OR AS A CONSEC	UENCE OF	j:								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.								7.25.95						
	PART II. Other significa	nt condition	e contributing to	deeth but not re	suiting i	n the un	derlyln	cause o	iven in	Part i. 24s	. WAS AN	AUTOPSY	24h.	WERE AUTOPSY FINDINGS
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IYSI	1 TYES 2 NO		-/	ER/Outpatient 3			Ing Hom		sidencs	8 Other (Sp				
ВУ РН	1 Natural 5 1 2 Accident	Pending Investigation	28s. DATE OF (Month, D	ay, Year)		M	1 🗆 1	PRK?] NO	28d. DESCRI				
ETED		Could not be determined	28a. PLACE C building,	F INJURY — At hor etc. (Specify)	ns, ferm, s	straat, facto	ory, offic			28f. LOCATIO City or To	N (Street si wn, State)	nd Number	or Rural Ro	oute Number,
COMPLETED			CIAN: To the best of a											and manner as stated.
TO BE C	Shahrar T	Tab	مرا					29c. LICE		BER 4 - 2	8	29d. DAT	1	(Month, Day, Year) 30,95
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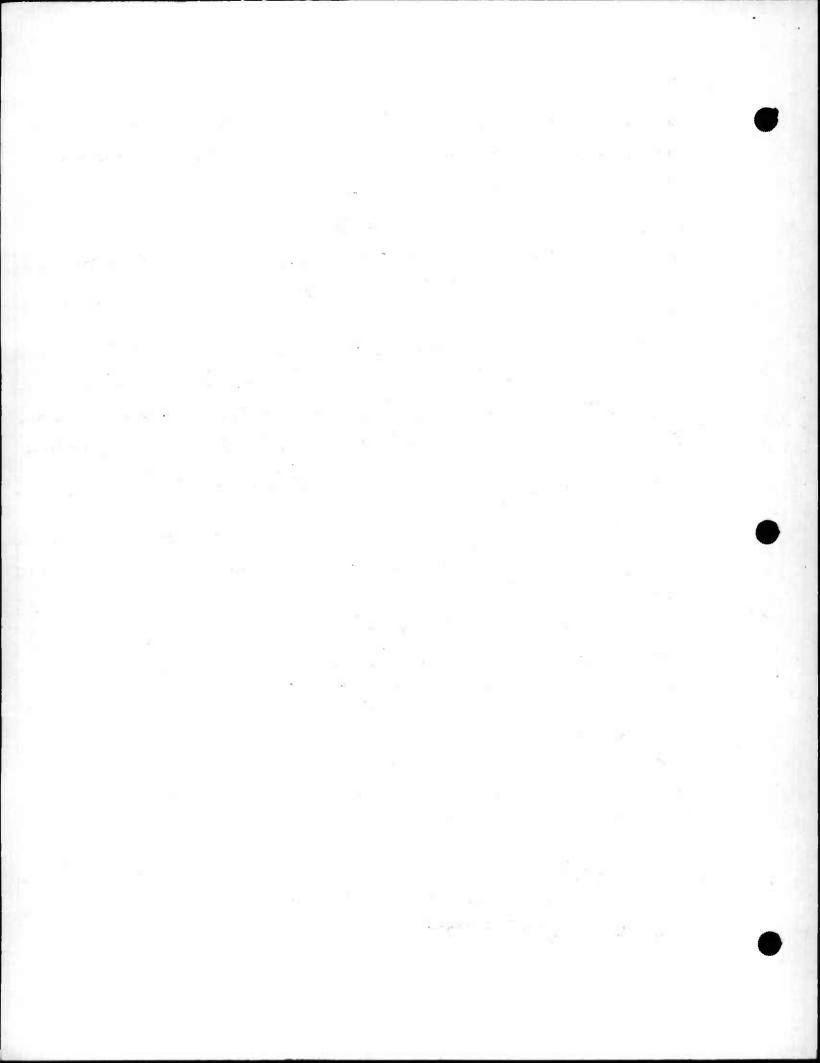
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATN 3. TIME OF DEATH Baumar 5:15 anette rev MONTH AM 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Country 01 0656 1 M 2 F DAYS HOURS BEIN. Pages 1, 2, 3 should 9a. FACILITY NAME (If not Institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH NA DIRECTOR ST ALASS H 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY PARYLAND BALTIMORE 1 YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? funeral director, page 5 should be detached for use as the burial-transit Hoice APT. 214 COA. D. 5 21228 ·A. hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 N NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married В 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 165 KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) ADMINISTRATIVE ASST. HOWARD COUNTY once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname REUT JOHO BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Milliam pe 20a, METHOD OF DISPOSITION

Company of the second s 20b. PLACE AND DATE OF DISPOSITION (Name of c. LOCATION - City or Town, State OATE must Removal from State ARK 4 Donation 6 Other (Specify) MARY medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ORUS HAPZLOF EVANS Non ARFORD and completely filled in by the oburial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory strest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween IMMEDIATE CAUSE (Final Onsat and Death End Sologe Co the disease or condition 6 Mas other traumatic event, resulting in death) executed RS Jamette CERTIFICATION Sequentially list conditions, DUE TO OR AS A CONSEQUENCE OF signed by the attending physician a Health and Mental Hyglene prior to if any, leading to immediate cause. Enter UNDERLYING Pe CAUSE (Disease or injury that initiated events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): 10 messin Injury, PARE IL Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? the MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 TYES 2 NO shows a engus 1 TES 2 NO t. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🔀 NO 🗌 UNCERTAIN 🗍 has be Dept. PHYSICIAN: Me. ន 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate ha Item **EXAMINER?** OTHER:
4 □ Nursing Name 5 □ Residence 6 □ Other (Specify) OR ATTENDING PHYSICIAN: 1 TES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 6 27. MANNER OF OEATN 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Acciden 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation Accident Sulcide 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 8 Could not be determined COMPLETED 4 Homicide Hem 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(s) and menner as ateted. THE HOSPITAL C THE FUNERAL D filed within 72 ho = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE D22875 27 195 Mes tunit 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3449 Wilkers AVE BALTO MB. 21229 31. DATE FILEO (Month, Day, Year)
AUG 0 2 1995 32. HEGISTRAR'S SUNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

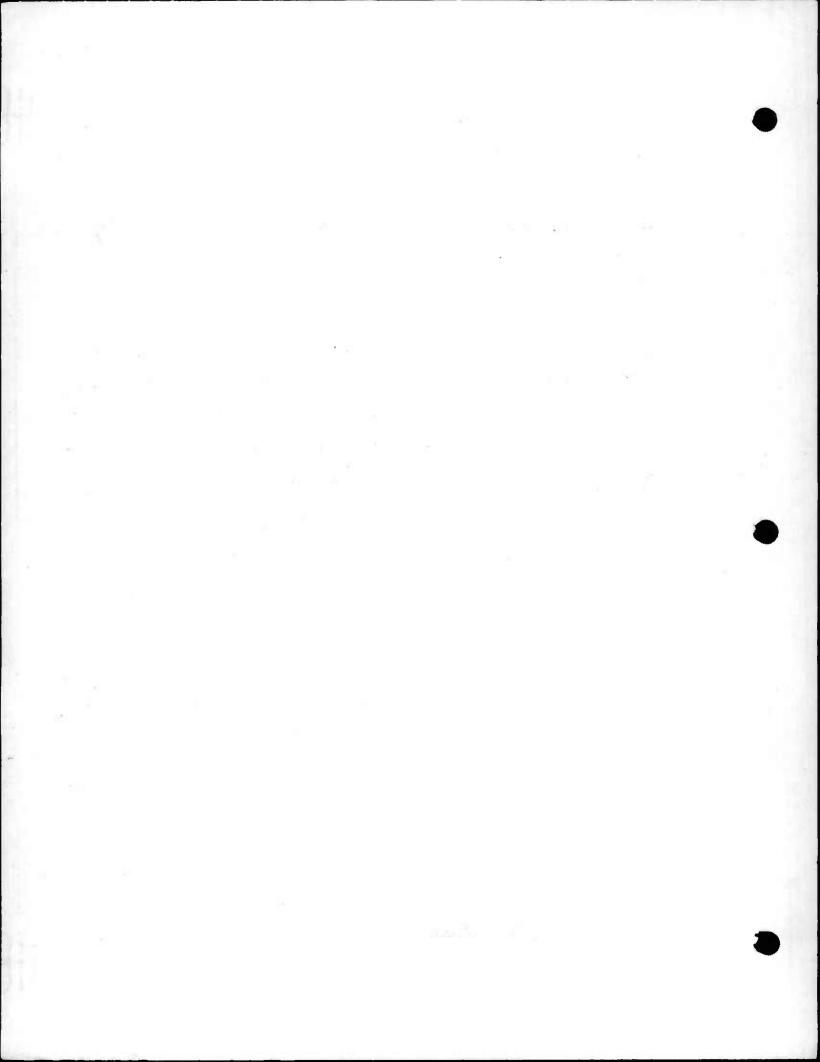
Dr. William
31. DATE FILED (Magth, Day, Year)

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Russell

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	1 - FOR STATE REGISTRAR	STATE OF M			TMENT OF			ENTAL HYGIE				
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	Emma Ma	rie Brov	vn							995	8:30	Ам
	4. SOCIAL SECURITY HUMBER		6. AGE (In yrs. lesi	t birthday)	IF UNDER 1 YEAR	-		DATE OF BIRTH (Month, Day, Year)	1919	8. BIRTH	PLACE (State or Fo	
	216-03-2193	1 🗌 M 2 💢 F	75	YRS.	MONTHS DAYS	HOURS	MIN.	ctober			vland	
	9e. FACILITY HAME (If not institution, give	street end number)			96. CITY, TOWI	OR LOCATION				HTY OF D		
8	De Paul House	е			Bal	timor	e			Balt	imore	
5	RESIDENCE OF DECEDENT											
DIRECTOR				10c. CITY	r, TOWN OR LOC						10d. INSIDE CITY LIMITS?	
	Maryland Ba.	<u>ltimore</u>		<u> </u>		timor	е				1 - YES 2 X	NO
N.						IOI. ZIP CODE			10g. CIT	IZEH OF V	WHAT COUNTRY?	
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BE	Jerome Cope	enspire					Jess	ie Lee	Char	mber	1and	
임	19e. IHFORMANT'S NAME (Type/Print)							te Number, City or To			21090	
	Mary Jacks						de R	Road Li				nd
	20a. METHOD OF DISPOSITIOH 1 □ Burlet 2 🗡 Cremation 3 □ Rem	novat from State	cametery, crer.	natory or ot	F DISPOSITION (!		OCATION -			
	4 Quantion 6 Other (Specify)	to the later of	Metr	o C	remato			2/95 Ca	tons	vil	le Mary	lar
	21. SIGNACINE OF PRINCIPLE SERVICE LI	CENSEE				AHD ADDRESS	OF FACILI	IIY				
	Town W Jag	a			2710	USE I	unei	ral Hom s Ferry	e or	Га	nsdowne	à
	23. PART i. Enter the diseases, or	complications that	csused the dec	eth. Do n	Dt enter the n	node of dvine	a. such a	s cardiac pr resi	SOX	reat.	Approxima	to.
	ahock, Dr haart failum.	List only one ceus	e on each line.		47.5.44.410.4	12.15	,		on all of	,	interval Ba	tween
- 1	immediate cause (Final disease or condition resulting in death) Disbetes Wellitus, Type II Onset and Death Ogys											
1	resulting in death)	DUE TO (OR AS A CONSEO	LIENCE OF	mus	1 7	re	4			10 9	15
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E	resulting in death) LAST											
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Ŧ	27. MAHHER OF DEATH	28e. DATE OF th	JURY	28b. TIME	OF 28c. II	JURY AT	-	d. DESCRIBE HOW	IHJURY OC	CURED		
	1 Natural 5 Pending	(Month, Day,	, Year)	MJU	44	YES 2 1						
BY	2 Accident Investigation 3 Suicide B Could not be	28e. PLACE OF	IHJURY — At hon	ne, ferm, at				of. LOCATIDH (Street	end Number	or Rumi A	huste Number	
E	4 Homicide 8 Could not be	building, et	tc. (Specify)			-		City or Town, State)	a. Awar Fi	_ to real name,	
91	29e. CERTIFIER					7						_
M P	(Check only CERTIFYING PHYS	ICIAH: To the best of m										
COMPLETED		ER: On the beals of exa	mmation and/or in	rvestigation	s, in my opinion,	geath occured	at the time	e, date end place, e	nd due to th	ne ceuse(s	end manner es sta	nted.
BE	296. SIGNATURE AND TITLE OF CERTIFIE	11000	7			29c. LICEN			29d. DAT	E SIGNED	(Month, Day, Year)	0 -
2	W-1000	Tul,				123	301	82		ulu	71 19	45
-	30. NAME AHD ADDRESS OF PERSON WH	IO COMPLETED CAUSE	OF DEATH (ITEM	27) (Type,	Print)					1	1	

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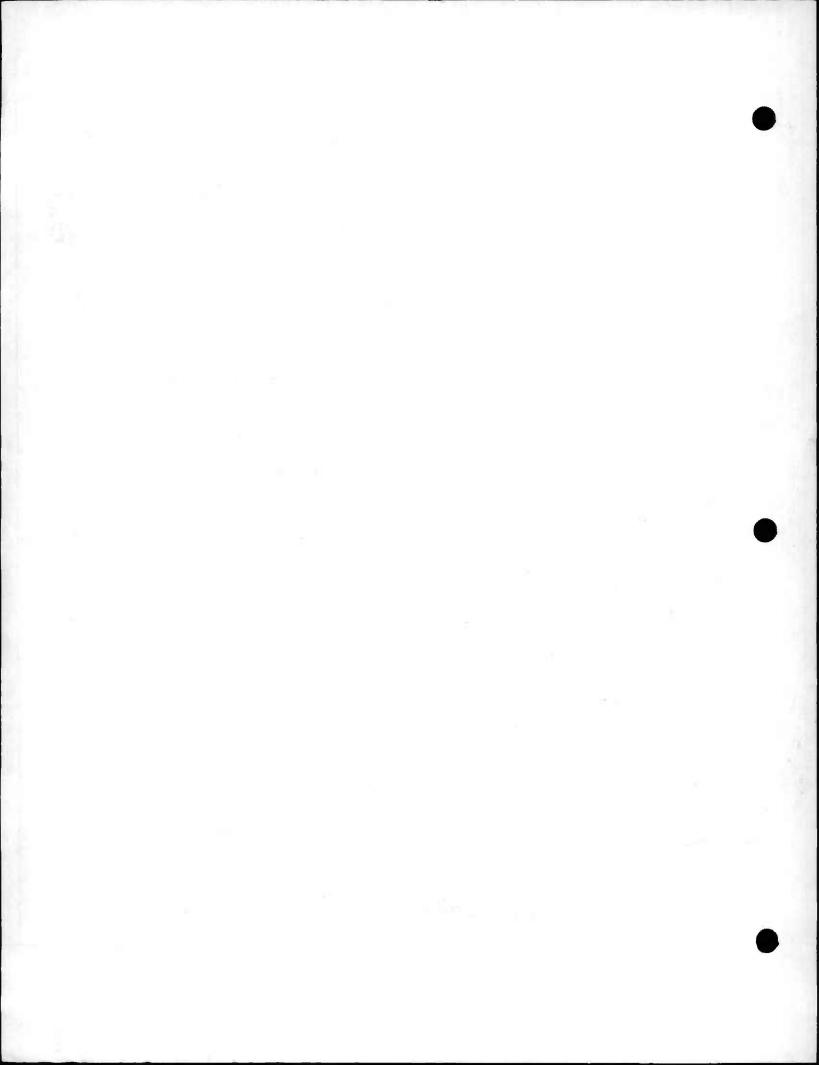
DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / D	EPARTM RTIFICA	ENT OF I	HEALTH AND	MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last	BURCA					2. DATE OF DEATH	9 10	3.	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 2/3-52-1287	5. SEX 6. AGE	(In yrs. last b	YRS. MON	UNDER 1 YEAR THIS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1,00	Country)	ACE (State or Foreign
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DIREC	10e. STATE 10b. COUN	ТҮ			WN OR LOCA				10	d. INSIDE CITY LIMITS?
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SON	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	AME (First, Middle, Malden		<u> </u>	-
BE (Laneaue Burch,	Jr.				Pea	arlean Cair	1		
2	19e. INFORMANT'S NAME (Type/Print)						Route Number, City or Tox	vn, State, Zip C	ode)	
	Pearlean Burch 200. METHOD OF DISPOSITION					n Avenue				
	1 X Burlel 2 Cremetion 3 Rer 4 Donation 5 Other (Specify)	moval from State Cen	netery, creme	atory or other p			Δ11/6	CATION — CI		
	21. SIGNATURE OF FUNERAL SERVICE L	/Garrisc	MILITY Nutter Funeral Homes Inc							
	2501 Gwynns Falls Parkway Baltimore Maryland 21216									mes, me
	23. PART I. Enter the diseases, or shock, or heart failure	complications that cause. List only one ceuse on e	d the desti	h. Do not s	nter ths mo	ods of dying, suc	ch as cardiac or resp	Iratory arres	st,	Approximats
	IMMEDIATE CAUSE (Finsi	F.12			0	•				Onset and Death
	disssee or condition resulting in death)	DUE TO (OR AS			AI	DZ				UNKNOW
NO	Sequentielly list conditions,	b. DUE TO (OR AS A	CONSEQUE	ENCE OF:						
AT	If any, leading to immediate cause. Enter UNDERLYING									
Ĕ	CAUSE (Disesse or injury that initisted events	DUE TO (OR AS /	CONSEQUE	ENCE OF):						
CERTIFICATION	resulting in death) LAST	d								
EDICAL C	PART II. Other significant condition	ens contributing to deeth b	out not res	uiting in th	e underlyin	g ceuse given in	Part I. 24a. WAS AN PERFO	RMED?	AW	RE AUTOPSY FINDINGS ALLABLE PRIOR TO MPLETION OF CAUSE DEATH?
Σ	DID TODA CCO HAT								1 [YES 2 NO
PHYSICIAN:	DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE TO	CAUSE	OF D		LACE OF DEATH (C)				
SIC	EXAMINER?	HOSPITAL:	patient 3 🗆		HER:		8 Other (Specify)			
¥	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF	28c. INJ	JURY AT DRK?	28d. DESCRIBE HOW	INJURY OCCU	RED	
<u>M</u>	1 Natural 5 Pending 2 Accident Investigation	(11011), 50, 1011)		11100111		YES 2 NO				
اد	3 Suicide S Could not be determined	28e. PLACE OF INJURY building, etc. (Spec	/ — At home cify)	, ferm, street	, fectory, offic	•	281. LOCATION (Street City or Town, Stete)	and Number or	Rural Route	Number,
COMPLETE		SICIAN: To the best of my know								
8	2 MEDICAL EXAMIN	ER: On the beele of exemination	n end/or Inve	estigation, in	my opinion, d	leath occured at the	time, date end piece, er	nd due to the	ceuse(e) en	d menner ee atated.
BE	296. SIGNATURE AND TITLE OF CERTIFII	ER MT				29c. LICENSE NU		29d. DATE S	SIGNED (MO	onth Day, Year)
2	31L HAME AND ADDRESS OF PERSON W	1 11				MRO8	27	+	129	195

31. DATE FILED (Month, Day 1995)

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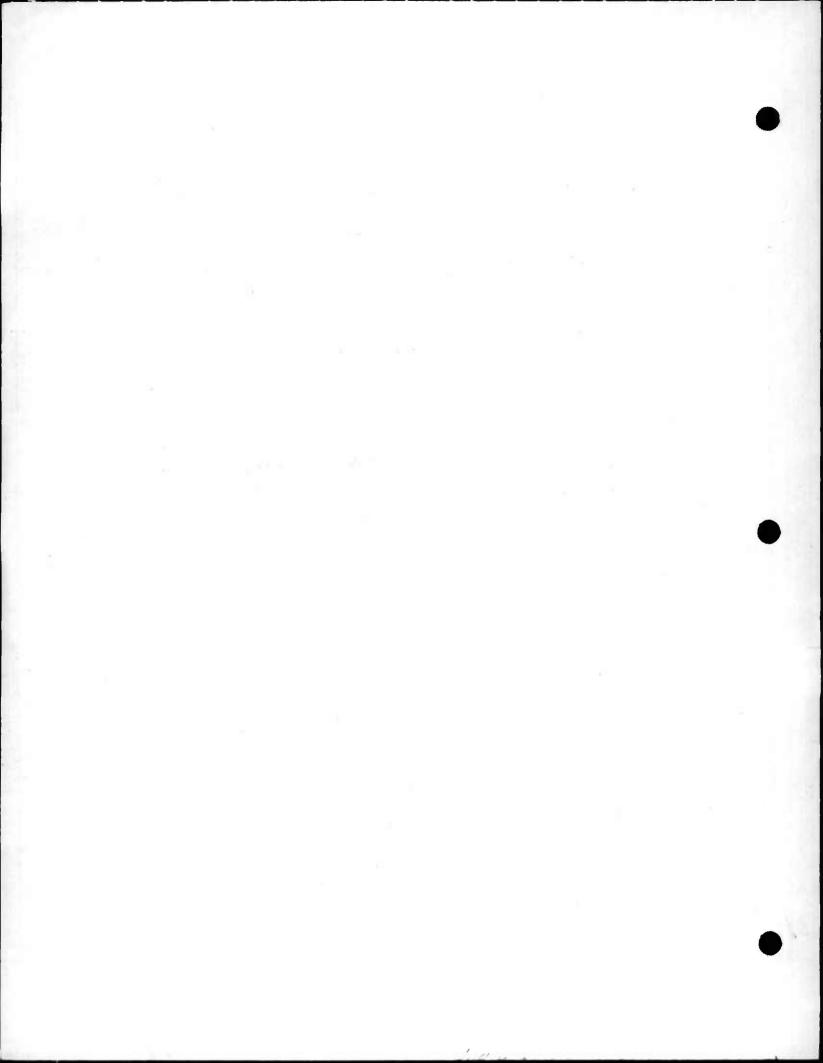
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BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	1

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH A. BISHOP WILLIAM JULY 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) S. BIRTHPLACE (State or Foreign 1 M 2 - F 88 NOV. 9, 217-05-2275 1906 MARYLAND Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR en Burnie nne Drunder EDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND SEVERN ANNE ARUNDET NO YES 2 NO funeral director, page 5 should be detached for use as the burial-transit permit. 10e. STREET AND NUMBER FUNERAL 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 785 QUEENTOWN ROAD 21144 USA. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 15 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuben, Mexicen, Puerto Ricen, stc.) 14. RACE — American Indian, Black, White, stc. 1 Never Merried 2 X Merried BY 1 TYES 2 XNO Specify: Specify: 3 Widowed 4 Divorced 12-4-42/ 10-24-45 BLACK 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) UNKNOWN TRUCK DRIVER TRUCKING COMPANY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) notified at BE JOHN BISHOP MARTHA 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 CATHERINE LOUISE BISHOP 785 OUEENTOWN ROAD SEVERN pe MARYLAND 21144 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must GARRISON FOREST CEMETERY 8+1-95 OWINGS MILLS. MD examiner 21. SIGNATURE OF FUNERAL SERVICE DICENSES JOSEPH H. BROWN JR. FUNERAL HOME, P.A. hours after death. 1913 W. BALTIMORE ST., BALTIMORE, MD.21223 completely filled in by the medicai 24. PART I. Enlay tha diseases, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one ceuse on each line ö Interval Batween **IMMEDIATE CAUSE (Final** Onset and Death cremation, event, the diseese or condition resulting in death) PNEUMONIA Nodans executed within DUE TO (OR AS A CONSEQUENCE OF): burial, CERTIFICATION traumatic been signed by the attending physician and one of Health and Mental Hygiene prior to buri Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? requires that shows any DEMENTIA 1 - YES 20 NO CORCEROVASILLAR ACCIDENT 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate to the State HOSPITAL: 1 TES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT marked, 28d. OESCRIBE HOW INJURY OCCURED With this 1 Netural 5 Pending investigation TO THE HOSPITAL OR ATTENDING PH TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death wi IMPORTANT: If Item 28 is marki 1 YES 2 NO BY 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 9 8 Could not be 4 Homicide determined COMPLET 29e. CERTIFIER 1 DE CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(e) end manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, data and piece, end due to the ceuse(a) and menner as atteted. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNEO (Month, Day, Year) 29c. LICENSE NUMBER BE M.D. 1345481 JULY 27 95 2 COMPLETEO CAUSE OF OEATH (ITEM 27) (Type, Print) CHARAFEDDINE MORTH ARUNDEL LOSP 1 PAL GLEN BURNE MD 21061 NIZER 37 REGISTAR'S SIGNATURE



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be executed within 24 hours after death. Page 6 may be ret.	10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit		IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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							95	23467	
	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	RTMENT OF I	HEALTH AND	MENTAL HYGIEN	E	2000	
	1. OECEDENT'S NAME (First, Middle, Last) HENRY BU 4. SOCIAL SECURITY NUMBER 218 - 64 - 1421	S. SEX 6. AGE		IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	2. DATE OF DEATH MONTH July 7. DATE OF BIRTH (Month, Day, Year)	29 95 8. BIR		
ron	90. FACILITY NAME (If not institution, give str UNION MEMO		PITAL	BALT	DR LOCATION OF D	EATH	9c. COUNTY OF	DEATH	
FUNERAL DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MARVLAND	NIA	10c. CIT	Y, TOWN DR LOCA	TIMORI	E CITY	/	10d. INSIDE CITY LIMITS? 1 YES 2 \(\square\) NO	
NERAL	10. STREET AND NUMBER 420 TUXEDO 11. MARITAL STATUS	STRE	ET	10	Z/	218	4	SA,	
B	1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 _ YES IF YES, GIVE WAR OR D	2 NO	If yes, sp	ENOENT DF HISPA ecity Cuban, Mexic 2 NO Speci	NIC DRIGIN? (Specify Yea an, Puarto Rican, atc.) fy:	or No— 14. RA Bli	ACE — American Indian, ack, White, atc.	
COMPLETED	15. OECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last)	ATION completed) College (1-4 or 5+)	(Give kind of life. Do NOT u	WORLD OCCUPATION Work done during me se retired.) RUCTION	st of working WORKE		RUCTION	COMPANY	
BE CC	HENRY J. B	BURTWELL			CAS	AME (First, Middle, Maiden	ELL	15	
2	19a. INFORMANT'S NAME (Type/Print)	HOMAS	196. MAILING		RICKER	Poute Number, City or Town	n, State, Zip Code)	21217	
	20a METHOD OF DISPOSITION 1 Source 2 Cremation 3 Ramo 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	val from Stata	D. PLACE AND DATE	of oisposition (Ne other place) NEM/	TERY ND ADDRESS OF FA	8-3-95 B	CATION — CITY OF ALTIMON	Town, State RE, MD,	
	•66	D. 110		Jose 1913	PH H. BR W. BALT	OWN JR. FUI IMORE ST.,		OMÉ, P.A. ORE, MD.21223	
	23. PART I. Enter the diseases, or conducts, or heart feliure. L. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Lat only one cause on a $End 5t4$	d the dasth. Do nach lina.	5	da of dylng, suc	h ss cardiac or reapi	ratory arrest,	Approximata interval Between Onset and Death	
TIFICATION	Sequentially list conditions, if any, leading to immediata cause. Entar UNDERLYING	DUE TO (OR AS /	A CONSEQUENCE D	F):				Unvertain	
CERTIFIC	CAUSE (Disease or injury that initiated events resulting in death) LAST		A CONSEQUENCE OF	F):					
PHYSICIAN: MEDICAL C	PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 ND 24b. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO								
CIAN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
BY PHYSIC	The state of the s					28d. OESCRIBE HOW INJURY OCCURED			
	3 Suicide 6 Could not be 4 Homicide detarmined	28s. PLACE OF INJURY building, stc. (Spec	' — At homa, farm, s cify)	street, factory, offic		28f. LOCATION (Street a City or Town, State)	nd Number or Rure	I Route Number,	
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER	IAN: To the best of my know	riedge, daath occurri	ed at the time, data on, in my opinion, d	and place, and due	to the cause(a) and man time, data and place, and	ner as stated.	e(a) and manner as stated.	
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	Do		7	29c. LICENSE NU	WBER 0 411/	29d. DATE SIGNE	ED (Month, Day, Year)	

DID TOBACCO 03E CONT	KIBUTE TO CAUSE OF DEA	ILL 1E2 🗀	NO L	UNCEKIAL	NI
25. WAS CASE REFERRED TO MEDICAL	26. PLAC	E DF DEATH (Che	ck only one)		
1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	DOA 4 N	OTHER: 4 □ Nursing Home 5 □ Resid		
27. MANNER OF DEATH	28a. OATE DF INJURY	28b. TIME OF	28c. INJUE		28

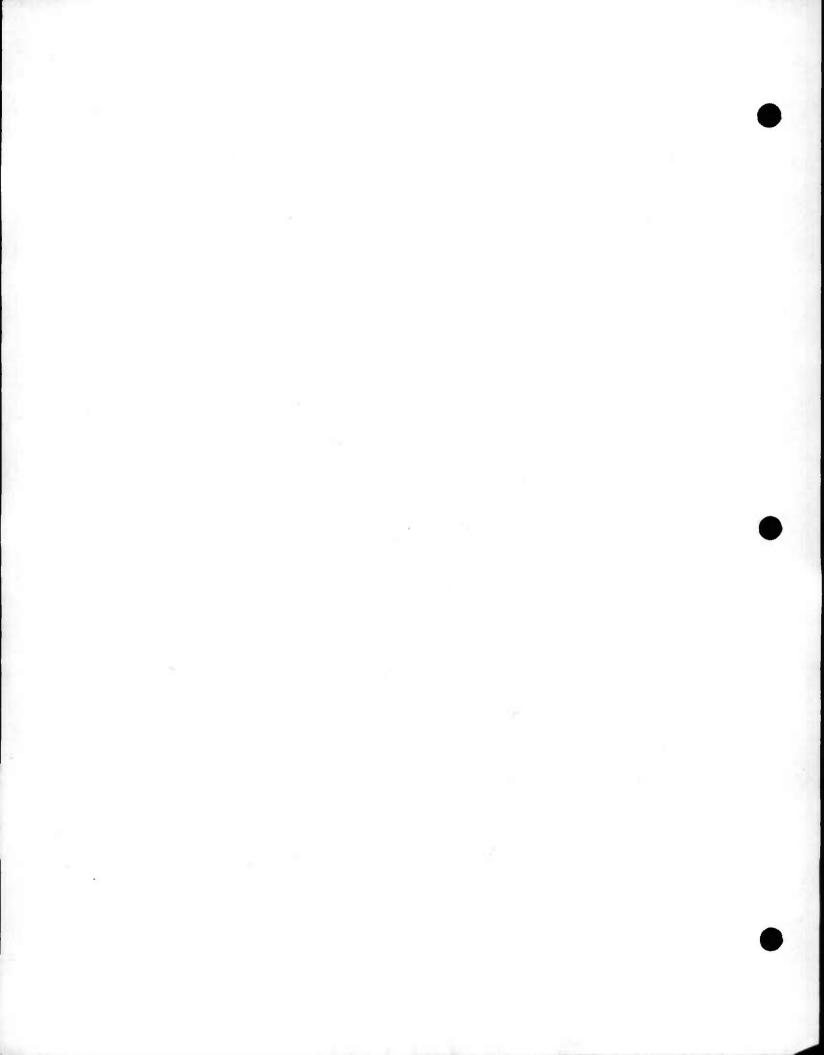
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Cart McKinney D. O.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

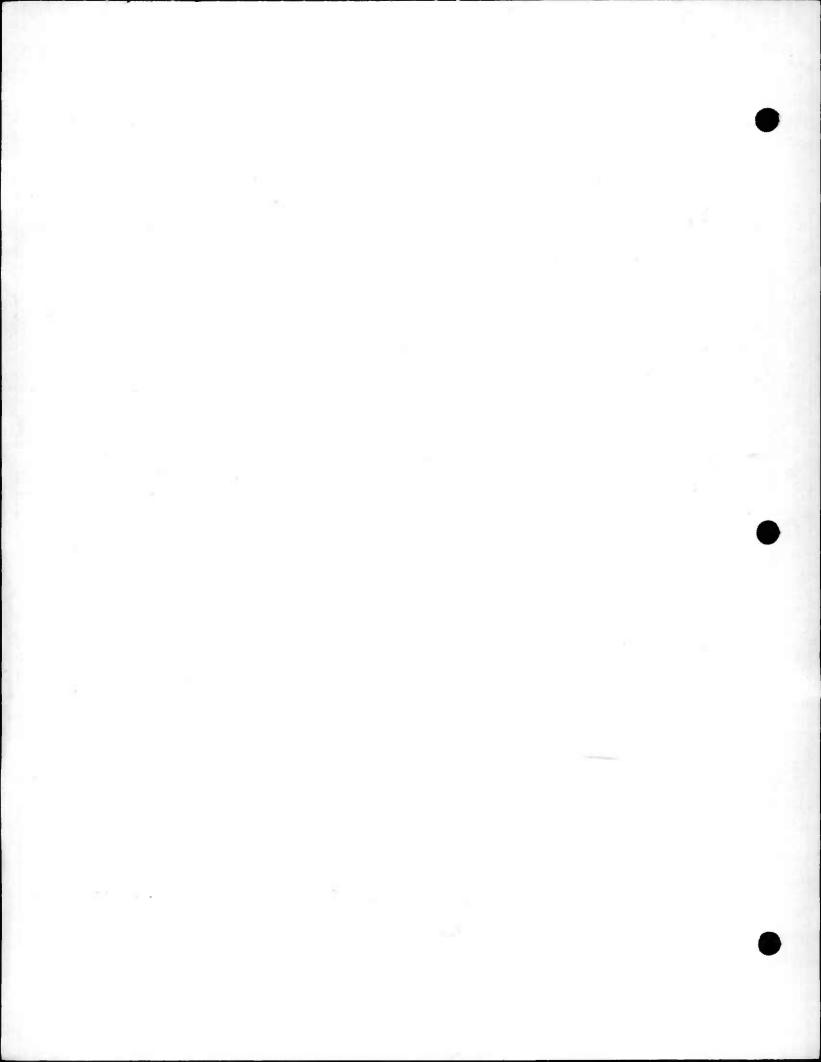
Robert Mckinney, 31. DATE FILEO (Month, Day, Year)
AUG 0 2 1995

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		FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF H	HEALTH AND	MENTAL	HYGIENE REG. NO.	Ē		
		1. DECEDENT'S NAME (First, Middle, Last) HARVEY	JAMES	BREWER			2. DATE OF MONTH	F DEATH DAY	1995	EAR	TIME OF DEATH 3:17 A M
Pi		4. SOCIAL SECURITY NUMBER UNKNOWN	1 <u>4</u> M 2 🗆 F	in yrs. last birthday) 45 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE Of (Month,		8.		ACE (State or Foreign
, 2, 3 should	СТОВ	98. FACILITY NAME (If not institution, give street and number) 851 GEORGE ST. APT 8B BALTIMORE CITY N/A								Н	
t. Pages 1,	DIREC	10a. STATE 10b. COUNTY MARYLAND N	/A	10c. CITY	Y, TOWN OR LOCAT	TION TORE CITY					d. INSIDE CITY LIMITS? X YES 2 NO
in. ransit permit.	VERAL	100. STREET AND NUMBER 2734 HARLEM AVE	NUE		.101	I. ZIP CODE 2121	16		USA		T COUNTRY?
215-0020 attending physician. use as the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEOENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yes, sp	CENDENT OF HISPA Hecify Cuban, Maxico 2 X NO Specific	an, Puarto Ric		or No — 14	RACE — Bleck, W Specify: BLAC	American Indien, hite, atc.
- 5 E	LETED	15. DECEDENT'S EDUC. (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5 +)	life. Do NOT us	vork done during ma e retired.)	ON ost of working			INESS/INOUS		
YLAND 2 by the hospital by the detached for at once.	COMP	11th GRADE 17. FATHER'S NAME (First, Middle, Last) AARON	SDENED	LAB	ORER	18. MOTHER'S NA	ME (First, Mic	RAILRO	Sumame)		
MAR retained 5 should	TO BE	19a, INFORMANT'S NAME (Type/Print)	BREWER			RUBY and Number or Rural AVENUE,	Route Number		,	ide)	21216
Page 6 may be al director, page ner must be		20s. METHOD OF DISPOSITION 1	20b.	PLACE AND DATE Of the left, cremetory or of ZION	F DISPOSITION (Na	ama of	OATE 3-2-95	20c. LOC	ATION — City	or Town,	
ALT death. funer:		#1. SIGNATURE OF FUNERAL-SERVICE LICE	MSEE		JOSEF 1913	PH H. BROW. BALTI	OWN FU MORE	NERAL ST.,	HOME, BALTIM	P.A.	MD.21223
ithmer hours afficiety filled in by emation, or remo	CATION	23. PART I. Entar the diseases, or consider the constant of th	NARCOTIC INT	ech ilne.		da of dying, aud	h as cardia	c or reapire	atory arrest	9	Approximata Interval Between Onset and Death
OX 68 be execute cian and cior to buria		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	·	CONSEQUENCE OF							
S, P.O. B' death certificate attending physi ental Hygiene pr ury, or other t	CERTIFIC	cause (Disease or injury that initiated events resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE OF):						
uires that the signed by the Health and M	MEDICAL O	PART II. Other eignificant conditions						PERFORM	MED?	CO OF	RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE OEATH? YES 2 NO
law law bept 23	SICIAN:		HOSPITAL:	28. PLACE OF DEAT		UNCERTAI	N 🗆				
NG PHYSICIAN free this certific sath with the S marked, or I	PHY	1 X YES 2 NO 27. MANNER OF DEATH 1 Neturel S Pending	1 Inpatient 2 ER/Outps 28a. DATE OF INJURY (Month, Day, Year)	FUUN	4 Nursing Hom OF 28c. INJ	PRK?	28d. OESCF	RIBE HOW IN	JURY OCCUR	ED	
) 5 4 5 m	red BY	2 Accident Investigation 3 Suicide S XX Could not be detarmined	FOUND 7/29/9 28a. PLACE OF INJURY building, atc. (Specia	- At home, farm, s	treet, factory, office	7430	UNKNOWN 281. LOCATION (Street and Number or Burel Route Number, City or Town, State) 851 GEORGE ST. #8B				
AL OR AL DIRI	COMPLET		IAN: To the beel of my knowle	edga, daath occurre	d at the lime, data		to the cause		ner an stated.	nuse(a) an	d manner en stated
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If	BE	296 SIGNATURE AND TITLE OF CERTIFIER	thee			29c. LICENSE NUI	MBER		29d. OATE SI	GNED (Mo	nth, Day, Year)
	0	30 NAME AND A CORESS OF PERSON WHO	COMPLETED CAUSE OF DEA	111 P	enn Sti			nore,		_	d 21201
		AUG 0 2 1995	32. REGISTRAR'S SIGNA	NTURE World							



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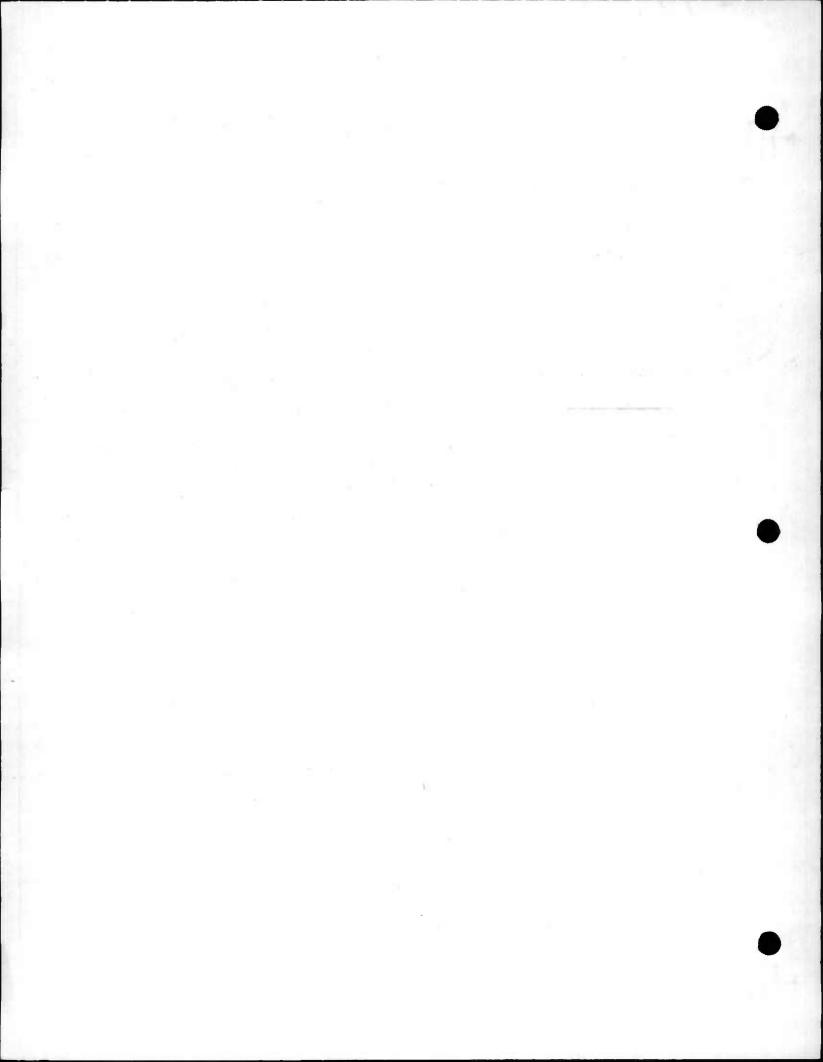
			1 - STATE REGISTRAR	STATE OF MARY	YLAND / DEPART CERTIFIC	MENT OF H	EALTH AND DEATH	MENTA	L HYGIENI REG. NO.	E			
			1. DECEDENT'S NAME (First, Midd	Ne, Lest)	-				OF DEATH		3.	TIME OF DEATH	
				ARLENE BOG	GS			JUI	LY 26	, 1995	1 1	9:00 P M	
	Pi	NO.	4. SOCIAL SECURITY NUMBER 216-42-7362	1 🗆 M 2 💢 F	55 YRS.	IF UNDER 1 YEAR HONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	SEPT	of Birth h, Day, Year) 19,	- 1	Country)	CE (State or Foreign Carolina	
	2, 3 should		90. FACILITY NAME (If not institution GOOD SAMARA'	on, give street and number) TIN HOSPITAL		96. CITY, TOWN O BALT]	EMORE	EATH		9c. COUNTY OF DEATH			
		닯	10a. STATE 10b.	10c. CITY	TOWN OR LOCAT	ION					I. INSIDE CITY		
	physician. burial-transit permit. Pages 1,	DIRECTOR	Md.	N/A	Ba	altimore)		1			LIMITS? XYES 2 NO	
	n. ansit per	FUNERAL	100. STREET AND NUMBER 1276 Cedarcroft Road 1620 Cedar Croft Road			101. ZIP CODE 21239					109. CITIZEN OF WHAT COUNTRY? USA		
215-0020	attending physician. se as the bunal-trar	ВҰ	11. MARITAL STATUS 1 X Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YI IF YES, GIVE WAR OF	ES 2 NO	13. WAS DECI	ENOENT OF HISPA ecify Cuban, Mexic 2 NO Speci	en, Puerto I	i? (Specify Yes Rican, atc.)	- 100.5	RACE — . Black, Wi Specify:	American Indian, nite, atc. White	
		TED	15. OECEDEN (Specify only highe	T'S EDUCATION est grade completed)	16a. DECEDENT'S U (Give kind of wo	rk done during mos	N st of working	18b	KIND OF BUS	INESS/INDUST	RY		
D 21	the hospital or att detached for use once.	COMPLET	Elementery/Secondary (0-12)	College (1-4 or 5+) N/A	life. Do NOT use	retired.)		١,	Handica	anned .	Indu	atav	
AN	detach	MO	17. FATHER'S NAME (First, Middle,		Labo	T T	16. MOTHER'S NA			1	LIIUU	SCITY	
=	के दे द	l w l	Earl K. Bog						I. Por	-			
MAF	5 should be notified at	TO B	19a. INFORMANT'S NAME (Type/Pri				nd Number or Rural						
шî			Earl K. Bogg		0333 B		ld Ave.,			Md.	2122		
0	e 6 ma ector, p		1 XBurlet 2 Cremetion 3 4 Donation 8 Other (Speci	☐ Ramoval from State	cemetery, cremetory or othe Meadowridg	er plecel		7/	31 E1				
F	death. Page e funeral dire il.		21. SIGNATURE OF FUNERAL SER		/	22. NAME AN	D ADORESS OF FA	WOILI I Y					
BAL			Jacke	e U. St	iannor	5695 N	L. Kauim <u>Main St.</u>	an Fi	Jneral	Home o	of E.	lk., Inc.	
•	they filled in by mation, or remo		23. PART Entar the disease shock, or heart find the shock of the shock	es, pr complicatione that ceu- failure. List only one cause of HYDROCEPHA!	aach iina.	t entar tha mod	de of dying, suc	ch ae cerc	diac Dr raspir	ratory arrest,		Approximeta interval Between Onset and Daeth	
õ	ficate be execute physician and cone prior to burian to burian to burian to the first transmatic to the first transmatic	RTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	с	S A CONSEQUENCE OF):								
о, С		CER	-3/-3/20-4/-011	d									
OR	w requires that the dea been signed by the att pt. of Health and Menta 3 shows any Injury,	MEDICAL	HYPERTENSION	enditions contributing to death	h but not rasulting in	tha undariying	cause given in	Pert i.	24a. WAS AN A PERFORI YES 2	MED?	AVA COI OF	RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO	
	3 2 2 -		DID TOBACCO USE C	CONTRIBUTE TO CAUSE	OF DEATH YES	□ NO □	UNCERTAI	N 🗆		_		123 2 10	
	In the law ficate has State Dep	PHYSICIAN:	25. WAS CASE REFERRED TO MED EXAMINER?	HOSPITAL:	26. PLACE OF DEATH	(Check only one)							
>	PHYSICIAN: The this certificate h with the State Erked, or Item	IXSI	1 XYES 2 NO	1 X Inpetient 2 ER/O	utpetient 3 DOA 4	☐ Nursing Home	5 Residence						
			1) Natural 5 Pendir	(Month, Day, Yea		NOE WOR	JRY AT RK? ES 2 NO	28d. DES	CRIBE HOW IN	JURY OCCURE	D		
DIVISION	OR ATTENDING I DIRECTOR: After hours after death Item 28 is man	ED BY	2 Accident Investi 3 Suicide 8 Could 4 Homicide determ	building, atc. (S	JRY — At home, farm, str specify)			281. LOC	ATION (Street er or Town, State)	nd Number or R	tural Route	Number,	
\leq	Se OH	9	29a. CERTIFIER	C BURNOUGHAN T. M. S. A. A. A. A. A. A. A. A. A. A. A. A. A.		=0.00 -							
	THE HOSPITAL THE FUNERAL I filed within 72 h PORTANT: If I	COMPLET		G PHYSICIAN: To the best of my kn EXAMINER: On the basis of examina							use(s) and	I manner as stated.	
	TO THE HOSPITAL TO THE FUNERAL I De filed within 72 h IMPORTANT: If I	BE	356 SURATURE AND TITLE OF CO	ERTIFIER NY Ke	11 ()		29c. LICENSE NU	MBER CME	T	29d. DATE SIG		1th, Day, Year)	
	F F & E	2	HAME AND ADDRESS OF PERS	SON WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, P			_			_		
			31. DATE FILED (Month, Day, Year) AUG 0 2	1995 37 PEGISTANTS S	111 Per	m stre	eet, Ba	TTT	поге,	mary.	ranc	21201	

e in Production — ear also not — All during the region — in the second region — in the seco

burlatransit permit. Pages 1, 2, 3 should TO BE COMPLETED BY FUNERAL DIRECTOR BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL DR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death. Page 6 may be immand by the TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at an examinary or contraction. DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR		STATE OF N		/ DEPAR ERTIF					/IENT/	AL HYGIEN REG. NO.	E		
1. DECEDENT'S NAME (First	, Middle, Last)	-							2. DAT	E OF DEATH			3. TIME OF DEATH
To	NIE	CH	ENO	WET	H . 5	R.			JUL-1 28th 1995			YEAR	
4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In yrs. I				IF UNDER	24 HRS.	7. DATI	E OF BIRTH			PLACE (State or Foreign
218-22-28	363	1 5 M 2 F	67	YRS.	MONTHS	DAYS	HOURS	MIN.	Oct	27,19	927	Country)
9a. FACILITY NAME (If not in		reet and number)			9b, CITY.	TOWN OF	LOCATIO	ON OF DE				Man	ryland
Northwest	Hospi	tal ce	nter			del		77.5				time	
RESIDENCE OF DEC	CEDENT		1001					W 11			Dul	OIM	71.0
10a. STATE	10b. COUNTY				Y, TOWN O				_	_			10d. INSIDE CITY LIMITS?
Maryland		imore		10	33 G	rov	ehi	11 1	Roa	d			1 TYES 2 NO
10e. STREET AND NUMBER						10f.	ZIP CODE				10g. CIT	IZEN OF W	HAT COUNTRY?
1033 Grov	/enill	Road					21	227			Uni	ted	States
11. MARITAL STATUS 1 Never Married 2	Chambad	12. WAS DECEDEN FORCES? †	T EVER IN U.S. A		13. V	WAS DECE	NDENT O	F HISPAN	C ORIGI	IN? (Specify Yea Rican, etc.)	or No-	14. RACE Black	- American Indian, White, etc.
3 Widowed 4 Divo		IF YES, GIVE V	AR OR DATES		1	YES :	NO	Specify.		, , , , , , , , , , , , , , , , , , , ,		Specif	y:
15. DEC	EDENT'S EDUC	April,		PECEDENT'S		CUBATION			1 40				nite
(Specify only	y highest grade	completed)		(Give kind of a	work done d			g	16	b. KIND OF BUS	INESS/INC	DUSTRY	
Elementary/Secondary (0	F-12)	College (1-4 or 5 -	,,	Pain	tor								
17. FATNER'S NAME (First, M	liddle, Last)			rain	CEI		10 MOTA	IED'C NAI	AE /Elmi	Const		tion	
George Ch		+h							111/1/2019	ah Rot			
19a. INFORMANT'S NAME (7		- 011	T.	ION MAILING	ADDRESS	(Street on				nber, City or Town			
Sreve Di		eve Dyke											Land21227
20s. METHOD OF DISPOSITI		eval from State	20b. PLACI	E AND DATE (OF DISPOSI	TION (Nam	eof		DA			City or Tow	
4 Donation 5 Other		-	Horr	aine						1 Wood	llaw	n, N	Maryland
21. Shanajame of Foresta	C SERVICE LIC	ENSEE	1	0				Film 6		1 Home	ь т	nc	Arbutus
the	67			250						pring			21227
23. PART I. Enter the di	seesea, or c	omplications the	t caused the c	deeth. Do n	not enter t	the mod	e of dyle	ng, such	ea cei	rdiac or reapi	ratory an	rest,	Approximate
IMMEDIATE CAUSE (Fin		list only one ceu	se on each lir	10.									Intarval Between Onaet and Death
disease or condition	→ .	RE	CTAL		- AN	CE	R						8 VEARS
l doubling in doubling			(OR AS A CONS										1 0 12
Comment to the state of													
Sequentially list conditi if any, leeding to immed	diete	DUE TO	(OR AS A CONS	EOUENCE OF	F):								
cause. Enter UNDERLYI CAUSE (Disease or Inju													
that initiated events reaulting in death) LAS		DUE TO	(OR AS A CONS	EOUENCE OF	F):								
PART II. Other significe	nt conditions	contributing to	death but not	resulting i	n the unc	derlying	ceuse q	iven in f	Part I.	24n, WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
13914										PERFOR	-		AVAILABLE PRIOR TO COMPLETION OF CAUSE
										1 🗌 YES 2	⊠ NO		OF DEATH?
DID TOBACCO U	SE CONTR	IBLITE TO CA	LISE OF DE	ATH VE	S \square N	ΙΩП	LINIC	ERTAIN					1 TES 2 NO
25. WAS CASE REFERRED TO		LOTE TO CA		CE OF DEAT			OIAC	LKIAIN					
EXAMINER?		HOSPITAL:			OTHER 4 Nursi	:	5 D 6	oldon 1		(Cara'i			
27. MANNER OF DEATH		28e. DATE OF	INJURY	28b. TIM	E OF	28c. INJUI		sidence (_	SCRIBE NOW IN	JURY OC	CUBED	
	Pending	(Month, Di	ay, Year)	INJ	URY M	WOR	K?	NO					i
3 Subside	Investigation	28e. PLACE O	F INJURY — At h	nome, farm, s	street, fecto	ry, office			281. LO	CATION (Street a	nd Number	or Rumi Br	uite Number
	Could not be determined	building,	etc. (Specify)	4/10					City	or Town, State)			
29a, CERTIFIER 1 CERT	IFYING PHYOL	IAN: To the best of	my knowledge		of me share at	na data	ad ola		- 44	Cin, come			
													and manner as stated.
29b. SIGNATURE AND TITLE										_ unu piece, enc			
IC NA		· RAO.	7.0					NSE NUMI		2	29d. DAT	E SIGNED (Month, Day, Year)
30. NAME AND ADDRESS OF		COMPLETED CAUS	E OF DEATH (IT	EM 27) /3ma	Print)			, 5	, ,		7	-	1 28th 1995
K.S. RAO	1. LI.C) , No	MTHW	F 37	H 020	TA	4	CE	NTI	EL, R	ANI	DAL	WTOWN,
31. DATE FILED (Month, Day,	n 2 190	32. REGISTRA	R'STEIGNATURE D'UNITE	Redel	4								



s hours after death, Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely DIVISION OF VITAL RECORDS, P.O. BOX 68769

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	rial, cremation, or removal.

		1 - STATE REGISTRAR	STATE OF MARY			F HEALTH AND I	MENTAL HYGIENI REG. NO.	E				
		1. DECEDENT'S NAME (First, Middle, L. JAMES	R. CONYE	RS			2. DATE OF DEATH MONTH 7/21/95	A AE	3. TIME OF DEATH			
Pir		4. SOCIAL SECURITY NUMBER 213 88 1128	1# M 2 □ F	(In yrs. lest birthday) 34 YRS.	IF UNDER 1 YEA		7. DATE OF BIRTH (Month, Day, Year) 7/4/61	8.	BIRTHPLACE (State or Foreign Country) MD.			
1, 2, 3 should	ECTOR	90. FACILITY NAME (# not institution, g (HOME) 2415 B RESIDENCE OF DECEDENT	ROOKFIELD AVE	•		NO OR LOCATION OF DE	ATH	9c. COUNTY BALT	O. CITY			
Pages	O.B.	10a. STATE 10b. CO			ALTIMO				10d, INSIDE CITY LIMITS? 1 ## YES 2 NO			
burial-transit permit.	FUNERAL	100. STREET AND NUMBER 2415 BROOKF				101. ZIP CODE 21217			OF WHAT COUNTRY?			
‡	BY	11. MARITAL STATUS 1 # Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 ☐ YES IF YES, GIVE WAR OR I	2 //NO	If yes	DECENDENT OF HISPAN A specify Cuben, Maxicae YES 2# NO Specify	, Puarlo Rican, etc.)	or No- 14.	RACE — American Indian, Black, White, atc. Specify: R. AMERICAN			
ed for use as	PLETED	15. DECEDENT'S (Specify only highest g Elamentary/Secondary (0-12)	EDUCATION trade completed) College (1-4 or 5+)	16a, DECEDENT'S (Give kind of w life. Do NOT us COURT C	rork done during e retired.)	MATION g most of working	DISTRIC	INESS/INDUST	'RY			
d be detached	SE COMPL	17. FATHER'S NAME (First, Middle, Lest,	CONYERS	1 00011 0	LLINK	18. MOTHER'S NAI	ME (First, Middle, Maiden S	Surname)	TOT HD:			
age 5 should be notified	TO B		NYERS			FIELD AVE,						
director, pa		20e. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 I 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	Ramoval from Stata cer	b. PLACE AND DATE Of metery, crematory or of WOODLAWN	PARK 7	//27/95	MOOE	DLAWN,	or Town, State			
filled in by the funeral director, page on, or removal.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217 23. PART Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
ompletely il, cremati event, ti	NO	23. PART I Enter the disease, shock of heart failu iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions,	a. My abao Due to (or as	Hemun A CONSEQUENCE OF	Avium	Intracel			intarval Between Onset and Death 3 Mu3			
ending physicial Hygiene prior or other trau	CERTIFICATION	sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): C. HUMAN Thumodley curvey Into										
2 2 2	MEDICAL (PART II. Other significant condi	tions contributing to death I	out not reaulting in	n the undari	ying cause given in I	Pert I. 24a. WAS AN A PERFORI	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
has been sign be Dept. of Heali m 23 shows	SICIAN: M	DID TOBACCO USE COI 25. WAS CASE REFERRED TO MEDICA		OF DEATH YE					1 □ YES 2 (8-110			
certificate h h the State d, or item	PHYSIC	EXAMINER? 1 VES 2 O	HOSPITAL: 1 Inpatient 2 ER/Out 26a. DATE OF INJURY	26b. TIME	OF 28c.	lome 5 asidence	Other (Specify) 26d. DESCRIBE HOW IN	JURY OCCURE	ED			
DIRECTOR: After this certificate has been signed hours after death with the State Dept. of Health aftern 28 is marked, or Item 23 shows an	р ву	1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not	28a PLACE OF IN HIR	f — A1 home, farm, st	M 1 [WORK? YES 2 NO	26f. LOCATION (Street as					
DIRE	COMPLETE	4 Homicide datarmine			d at the time of	tele and place and due	City or Town, State)					
FUNERAL within 72 TANT: II			HINER: On the basis of examination			n, death occured at the t	lme, data and place, and	I dua 10 tha ca				
THE DE FILED	TO BE	30. NAME AND ADDRESS OF PERSON	rmo	TATIA (ITEM 27) (See	Defeat)	P87785	reget	▶7. 5	25.95			
		L Melchid Y 31. DATE FILED (Month, Day, Year)	295out	to Paco	184.	BALTO	UD 212	01				
	Ч		95 Jahre Study	orkedsk								

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ES 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 251-24-7018 1 XM 2 F 26, SOUTH CAROLINA 77 AUG. 1917 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH N/A DIRECTOR BALTIMORE BON SECOURS HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND N/A BALTIMORE 1X YES 2 NO funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21223 USA. 2032 W. SARATOGA STREET the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY 1 TYES 2 NO Specify Specify: 3X Widowed 4 Divorced 12/6/43 - 12/18/45 BLACK COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 5th GRADE GAS CONSTRUCTION WORKER BALTO. GAS & ELECTRIC CO. 17. FATHER'S NAME (First, Middle, Last) ta. MOTHER'S NAME (First, Middle, Malden Surname) ALEX CLARK retained by 1 ANNIE BELL ROBINSON BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 В. CLARK TDA 2032 W. SARATOGA STREET, BALTIMORE, MD. 21223 Page 6 may be pe 20e. METHOD OF DISPOSITION
1 № Burlel 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Nama of 20c. LOCATION - City or Town, State OATE must GARRISON FOREST CEMETERY 8-5-9 Donation S Other (Specify) OWINGS MILLS, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. death. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD.21223 miled in by the fundament. after medical 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate ehock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel Onset and Death the cremation. disease or condition_ and completery in burial, cremation resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760. OR AS A CONSEQUENCE OF): executed wi unuma traumatic CERTIFICATION Sequantially list conditions, THE TO (OR AS A CONSEQUENCE OF): prior to l if eny, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to CAUSE (Diseese or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 PART/IT Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMEO? MEDICAL Health and 02 any 1 TYES 2 NO OF OFATH? 1 ☐ YES 2 ☐ NO has been of h PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) The the State of item HOSPITAL:
1 Unipellant 2 ER/Outpellant 3 DOA OTHER 1 | YES 2 1 NO 4 - Nursing Home 5 - Residence 6 - Other (Specify) 10 27. MANNER OF DEATH 28a. DATE OF INJURY this c with t 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending Investigati м 1 YES 2 NO BY After OR ATTENDING 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 DIRECTOR: A hours after d item 28 is COMPLETED 8 Could not be 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. FUNERAL (HOSPITAL = 2 MEDICAL EXAMINER: On th ition and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 296. SIGNATURE AND TITLE OF CONTIFIES 29d. DATE SIGNED BE 223 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

W

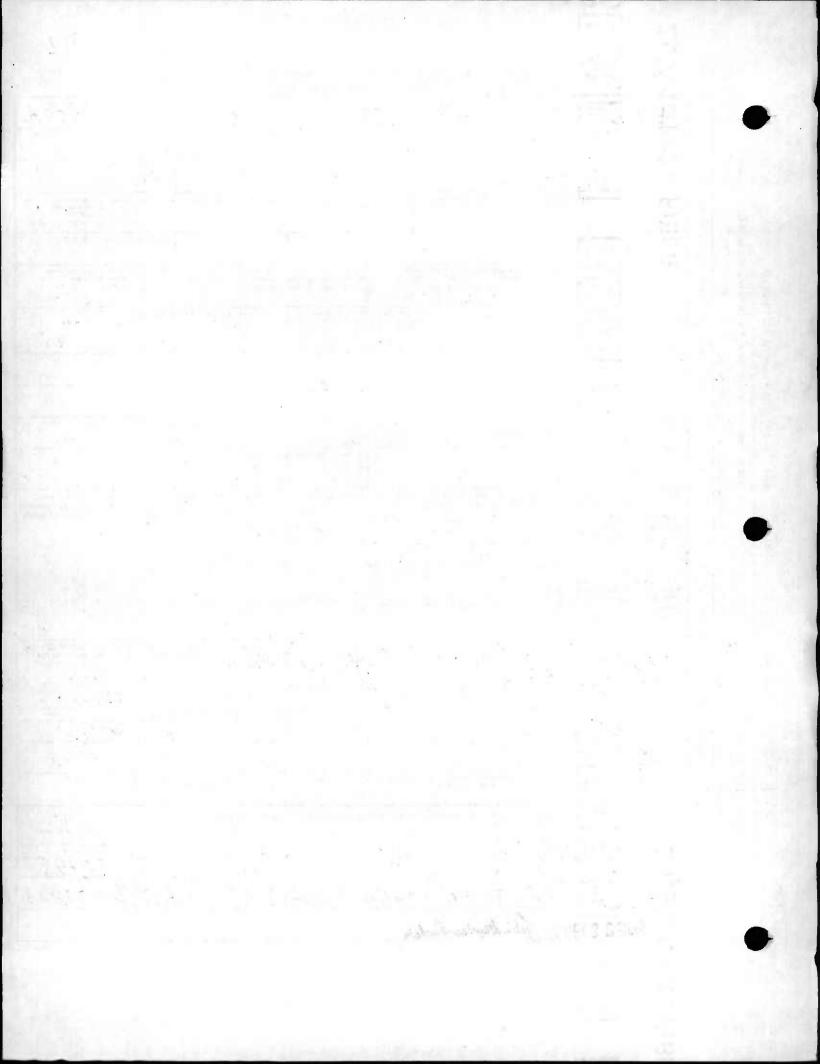
940

2. REGISTRAR'S SIGNATURE

5+1

31. DATE FILED (Month, Day, Year)

2 199



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Wicciam (occins 95 18:45 M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (S 1 M 2 D F YRS. permit. Pages 1, 2, 3 should FACILITY NAME (# not 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 VES 2 NO FUNERAL 10e. STREET AND NUMBER CODE 10g. CITIZEN OF WHAT COUNTRY? urlai-transit 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yea, specify Culpan, Maxican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE - American Indias BALTIMORE, MARYLAND 21215-0020 1 W Never Married 2 Married BY IF YES, GIVE WAR OR DATES 1 TYES 2 THO Specify: Specify: 3 Widowed 4 Divorced COMPLETED 16s. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 15. OECEDENT'S EDUCATION 16b. KING OF BUSINESS/INQUISTRY (Specify only high working College (1-4 or 5 +) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surriame) retained by the 8 Ħ BE page 5 should notified INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Str 2 hours after death. Page 6 may be 2 METHOD OF DISPOSITION
Burial 2 Cremation 3 Removal from Stale 20b. PLACE AND DATE OF DISPOSITION OATE must funeral director, 4 Donation 8 Dother (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACH ITY filled in by the medical 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest, Approximata shock, or heart failure. List only one cause on each line interval Between 0 n and completely filled to burial, cremation, c IMMEDIATE CAUSE (Final Onset and Death event, the disesse or condition END-STAGE AIDS resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 OUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSPONENCE OF) 2 if any, lasding to immediate cause. Enter UNDERLYING signed by the attending physician. Health and Mental Hygiene prior to that the death certificate be CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY PERFORMED? shows any 1 TES 2 NO requires OF OEATH? 1 - YES 2 1 NO been : DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO X UNCERTAIN has b OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one ltem! After this certificate death with the State HOSPITAL:
1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d. OESCRIBE HOW INJURY OCCURED marked, 1 Netural 5 Pending Investigation м 1 YES 2 X NO В Accident 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28s. PLACE OF INJURY — Al home, farm, streel, lactory, office building, sic. (Specify) 69 3 Sulcide DIRECTOR: / COMPLETED 8 Could not be 4 Homicide 28 determined **Tem** 29s. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF THE FUNERAL DE FIED WITHIN 72 ho HOSPITAL 2 MEDICAL EXAMINER: On the basis of axi mination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 7/17/95 MI 90 2 30. NAME AND ADDRESS COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) ARTEH B-6753 Umms ESS4H 31. DATE FILED (MATT) 32. REGISTRARE GIGNATURE

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DIVISION OF VITAL RECORDS, P.O. BOX 13146,	ires that the death certificate be exect
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ECO	requires
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OF	IR ATTENDING PHYSICIAN
NO NO	NDING
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er this certificate has been signed by the attending physician and completely 📞 in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	ath with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE FUNERAL DIRECTOR: After this certificate has bee	be filed within 72 hours after death with the State Dept. o	IMPORTANT: If Item 28 is marked, or item 23 sh

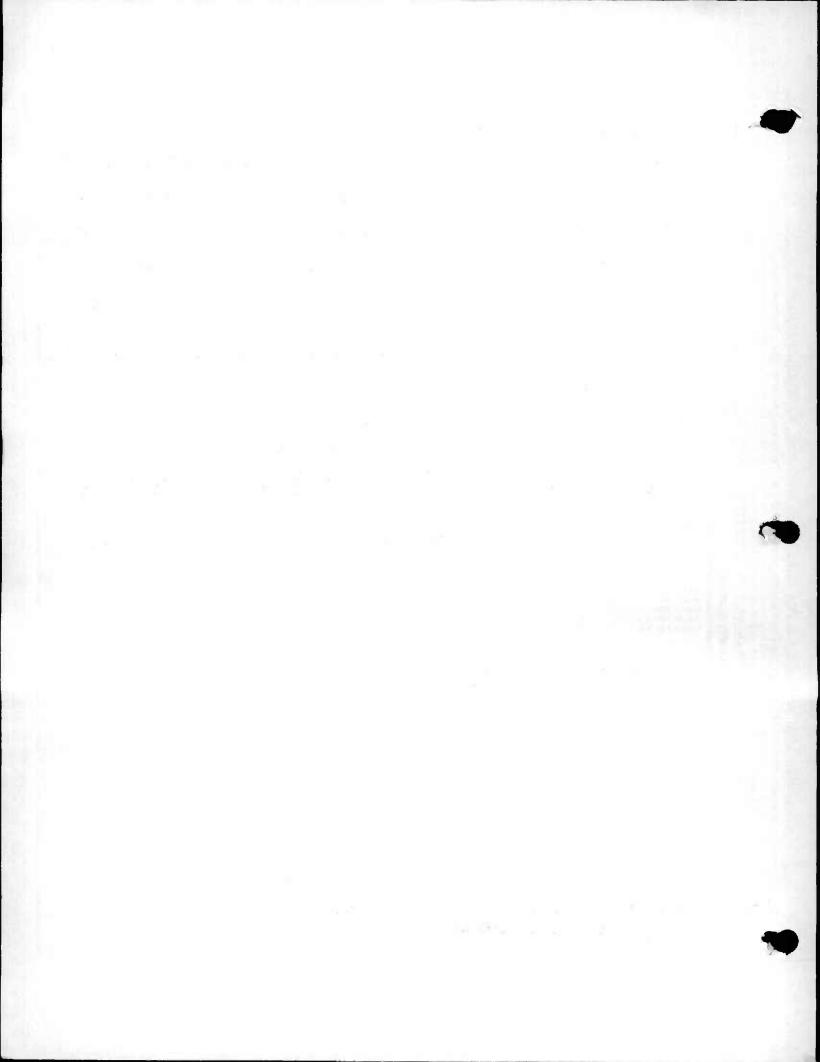
	FOR STATE REGISTRAR	STATE OF !	/ARYLAND /		TMENT					YGIENI REG. NO.	E		
	1, OECEOENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH			3. TIME OF DEATH
- 1			C+1						MONTH	DA		YEAR	
	Jane El:				_	_			July		1 †	995	9:10pm M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER	DAYS	HOURS	MIH.	7. DATE OF (Month, D			6. BIRTH Country	PLACE (State or Foreign y)
	215-14-1385	1 M 2 X F	77	YRS.	MONTHS	CANTO	noons		Aug.		1917	Pe	nnsvlvania
- 1	9a. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY	, TOWN	OR LOCAT	ON OF DE				NTY OF D	
α	Corbonosiala Dadon												
2	Sykesville Elder	care Cer	ter			S	ykes	vill	e		l Ca	irro	11 County
DIRECTOR	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN (TOWN OR LOCATION 10d. INSIDE				10d. INSIDE CITY			
<u>=</u>	Maryland Car	roll Cou			Sykesville					- 1	LIMITS?		
		TOIL COL	шьу		-								1 YES 2 NO
₹	10e. STREET AND NUMBER				101, ZIP CODE 10g. CITIZEN OI				ZEN OF W	VHAT COUNTRY?			
FUNERAL	413 Obrecht Roa	.d						2178	4		U.	S.A	
5	11. MARITAL STATUS		IT EVER IN U.S. AR						NIC ORIGIN? (or No-	14. RACE	E — American Indian,
	1 Never Married 2 X Married	FORCES? 1	YES 2 XI	NO				an, Maxica Specifi	in, Puerto Rici	in, etc.)	- 1	Speci	k, White, etc.
BY	3 Widowed 4 Divorced						-/-	- oprom	,.			-	Black
	15. DECEDENT'S EDUC		16a. DE	CEDENT'S	USUAL O	CCUPATION	ON		16b. KI	ND OF BUS	SINESS/IND	USTRY	
E	(Specify only highest grade	,	ille	ive kind of Do NOT u	work done se retired.)	during mo	st of work	ing	23.00				
اچ	Elementary/Secondary (0-12)	College (1-4 or 5	+)			,			Ed	lucat		/ 11.	aalah Cama
COMPLETED		4		Tea	cher		Nurs		_			/ He	ealth Care
8	17. FATHER'S NAME (First, Middle, Last)						16. MOT	HER'S NA	ME (First, Mide	die, Maiden	Surname)		
BE	William	Brightf	ul					Anna	More	an			
	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILIN	ADDRES	S (Street a	and Numbe	or or Rural	Route Number,	City or Tow	n, State, Zip	Code)	
2	Mr. Eldridge Cost	lev		413	Ohre	oht	Pos	d Sarl	kesvil	10	MD 21	70%	
	20s. METHOD OF DISPOSITION	10)	20b. PLACE						KESVII	_	CATION —		wn State
	1 Surial 2 Cremation 3 Ram	oval from Stata	other pl	ace)					1.10=				
	4 Donation 5 Other (Specify)		_ wni	се к					/4/95	Sy.	kesvi	.lle	, MD
	21. SIGNATURE OF JUNERAL SERVICE LIC	ENSEE	1/ 1	4	22.			ESS OF FA		OME	(D 0		105)
	Brian	× 4	Haise	1		na.	TGHI	FUN.	EKAL H	IUME	(P. U.	BOS	x 195)
	no page 1 Salas the discourse	, 0 (- 6		in m.									95-1400
	23. PART I. Entar tha diseases, or cahock, or heart failure.				not ente	r the mo	ae or ay	/ing, suc	n as cardia	c or respi	retory arr	est,	Approximata Interval Between
	IMMEDIATE CAUSE (Final												Onaet and Death
	disease or condition	. B	iliary 7	Fract	Car	cin	oma						months
	resulting in death)		(OR AS A CONSE				o in c						
_1	_												
CERTIFICATION	Sequentially list conditions,	bDUE TO	(OR AS A CONSE	OUENCE (OFI:								+
F	If any, laeding to immediata ceuse. Enter UNDERLYING												
2	CAUSE (Disease or Injury	C. DUE TO	OR AS A CONSE	OUTNOE (_
늗	that initiated events resulting in death) LAST	DOE IC	(OR AS A CONSE	OUENCE (e):								i
1	resulting in death, EAST	d											
	PART II. Other algolificent condition	a contribution to	doeth but not	no a cital man	In the st	- d - ds de		eline le	Don't I	4a. WAS AN	ALETODON	100	. WERE AUTOPSY FINDINGS
¥		_		resurting	in the u	noeriyii	d cansa	Given in	Part I. 2	PERFOR		240	AMILABLE PRIOR TO
용	Acute Ren								1	YES 2	X NO		OF DEATH?
	Coronary	Artery D	isease										1 YES 2 NO
-		-							_				
PHYSICIAN: MEDICA	25. WAS CASE REFERRED TO MEDICAL					26. P	LACE OF	DEATH (C)	heck only one)				
$\overline{\Omega}$	EXAMINER?	HOSPITAL:		_	OTHE	R:							
YS	1 YES 2 X40		☐ ER/Outpatient :			_		Residence	6 Other (S				
표	27. MANNER OF DEATH	28a. DATE O (Month,	F INJURY Day, Year)	26b. TI	ME OF JURY		JURY AT ORK?		28d. DESC	RIBE HOW	NJURY OC	CURED	
ВУ	1 X Natural 5 Pending 2 Accident Investigation				M	1 🗆	YES 2	□ NO					
	3 Suicide 6 Could not be	28e. PLACE	OF INJURY - At h	ome, farm,	atreet, fac	ctory, offi	en .		26f. LOCAT	ION (Street	and Number	r or Rural i	Route Number,
E	4 Homicide determined	Donaing	, atc. (Specify)						City of	Town, State)			
ш	29a, CERTIFIER												
d l	(Check only 1 K.) CERTIFYING PHYS												
COMPLETED	2 MEDICAL EXAMINE	R: On the basis of	examination and/or	Investigat	ion, in my	opinion,	death occ	ured at the	o tima, data ar	nd place, ar	nd due to th	te cause(a) and manner as stated.
Ш	296. SIGNATURE AND TITLE OF CERTIFIE	RIANA A-	515				29c. LI	CENSE NU	MBER		29d. DAT	E SIGNEC	(Month, Day, Year)
8		WINCH .	SMI				Т	3368	31		D o	-1-9	5
5	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAI	JSE OF OEATH (ITE	M 27) (7vs	e. Print)			,,,,,,,	- L			-T-A	

College Avenue, Sykesville, MD 21784

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D.

M.K. McEvoy, 31. DATE FILED (Month, Day, Year) AUG 0 2 1995



of the bursal physician.

BALTIMORE, MARYMAND 21245-0020 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYG			
	1. DECEDENT'S NAME (First, Middle, Lest) Cooper Davenport KATANYA DENISE DAVENDORT J							3. TIME OF DEATH 06:00 Pm	
	4. SOCIAL SECURITY NUMBER 213-84-7419	7. DATE OF BIRT	E OF BIRTH 8. BIRTHPLACE (State or Foreign						
TOR	99. FACILITY NAME (If not institution, give street 6605 ELLSMERE RESIDENCE OF DECEDENT		EATH	9c. COUNTY OF DEATH BALTIMORE					
DIRECTOR	10e. STATE 10b. COUNTY	/a 8altimor	e 10c. CIT			10d. INSIDE CITY LIMITS? 1 YES XX NO			
FUNERAL	100. STREET AND NUMBER 6605 ELLSMERE	PLACE		101	ZIP CODE	1		ZEN OF WHAT COUNTRY? TED STATES	
D BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2 YOU If yes, specify Cuban, Mexican, Puerto R						14. RACE — American Indian, Black, White, atc. Specify: BLACK	
VE.	15. DECEDENT'S EDUCA' (Specify only highest grade co	ompleted) College (1-4 or 5+)	18e. DECEDENT'S (Give kind of a life. Do NOT us	USUAL OCCUPATION WORK done during more retired.) SERVICE	ost of working	SOCIA	SECU		
DIMO:	17. FATHER'S NAME (First, Middle, Last)	years	TELLER	SERVICE	18. MOTHER'S NA	ME (First, Middle, M	aiden Surneme)	RITY ADM.	
BE, COMPL	BENNIE COOPER	JR.			L	ILLIE M.			
10	BENNIE COOPER	0111	5712	NORTH	NOOD DR	IVE, BAL		MARYLAND	
	20a. METHOD OF DISPOSITION 1X Meuriel 2 Cremation 3 Removal from State 4 Donatton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Cametery, Crematory or other place) DULANEY VALLEY CEMTERY 8-3 TOWSON, MARYLAND								
	21. SIGNATURE OF FUNERAL SERVICE LICEN	te K.	ans	1	O. MARCH				
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cerdiac or respiratory arrest, ehock, or heart failure. List only one ceuse on sech line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Approximate interval Betw Onset and D. Out To (or as a consequence of):								
CERTIFICATION									
MEDICAL CI	PART II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE								
N.	DID TOBACCO USE CONTRIE	BUTE TO CAUSE C			UNCERTAI	v 🗆	. 6	1 YES 2 NO	
SICIAN:		OSPITAL:	28. PLACE OF DEAT	OTHER:	e 5X Residence	th [] Outhorn (Oncore)			
PHY	27. MANNER OF OEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI	E OF 28c. INJ	URY AT	28d. DESCRIBE H	OW INJURY OCC		
B	2 Accident Investigation 7 29 95 1752PM 1 YES 2 TNO WASSEYSTABLED AND CULT								
TED	3 Suicide 6 Could not be detarmined 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 26e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLETED		N: To the best of my know	ledge, death occurre			to the cause(a) and		ed. e ceuse(a) and menner as stated.	
BE C	299. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI			E SIGNED (Month, Day, Year)	
10 E	30. NAME AND AODRESS OF PERSON WHO C	COMPLETED CAUSE OF OR	ATH (ITEM 27) (3	Point)	O.C.M	.Е.	▶ Jī	ULY 30 1995	
	MARRONAD A. KO	Reu fin	111 P		ceet, B	altimor	e, Ma	ryland 21201	
	AUC 0 2 1995	32 AGGISTRIA'S SIGN	erharball					13-5	

Pages 1, 2, 3 should

funeral director, page 5 should be detached for use as the burial-transit permit. hours after death. Page 6 may be retained by the hospital or attending physician **BALTIMORE, MARYLAND 21215-0020** executed with DIVISION OF VITAL RECORDS, P.O. BOX 68760

signed by the attending physician and completely filled in by the I Health and Mental Hygiene prior to burial, cremation, or removal. other traumatic has b. Dept. 23 certificate I OR ATTENDING PHYSICIAN: the this c After 1 .00 DIRECTOR: J 200 tem TO THE HOSPITAL (TO THE FUNERAL C be filed within 72 h

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LARON

LOCKE

95 23476 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JULY 2 7 , 1995 BRUCE ALLEN **DEANS** 11:54 Am 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH OCT.1, 1956 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign Country) 38 DAYS HOURS 217-68-2114 1 XX M 2 - F CAROLINA 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c, COUNTY OF DEATH DIRECTOR 1330 ASOUITH STREET n/a BALTIMORE RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE n/a Y YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21202 UNITED STATES **AISOUITH** STREET 1330 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YOU IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married It yes, specify Cuban, Mexican, Puarto Ri
1 YES 2 NO Specify: BY 3 Widowed 4 Divorced Specify: **BLACK** COMPLETED 16e. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 10 TH LABORER CONSTRUCTION 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) at WILLIAM **DEANS** LORICE BE SHERROD notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 LORICE DEANS 1330 AISOUITH STREET, BALTIMORE, MD 21202 20a. METHOD OF DISPOSITION

1% XBurlel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Spacify) pe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State must BALTIMORE" CEMETERY 8-2 BALTIMORE, MARYLAND medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH **AVENUE** 23. PART I. Enter the measures, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. Approximata Interval Between **IMMEDIATE CAUSE (Final Onset and Death** event, the disease or condition CONGESTIVE HEART FAILURE reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Cardiovascular Disease CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? any 1 YES 2 XNO 1 TES 2X NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 X YES 2 - NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending 1 YES 2 NO BY 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Nomicide 29a, CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 X MEDICAL EXAMINER: On the examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated. ATURE AND TITLE OF CENTIMER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. PROISTEAR'S SINCE

M.D

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

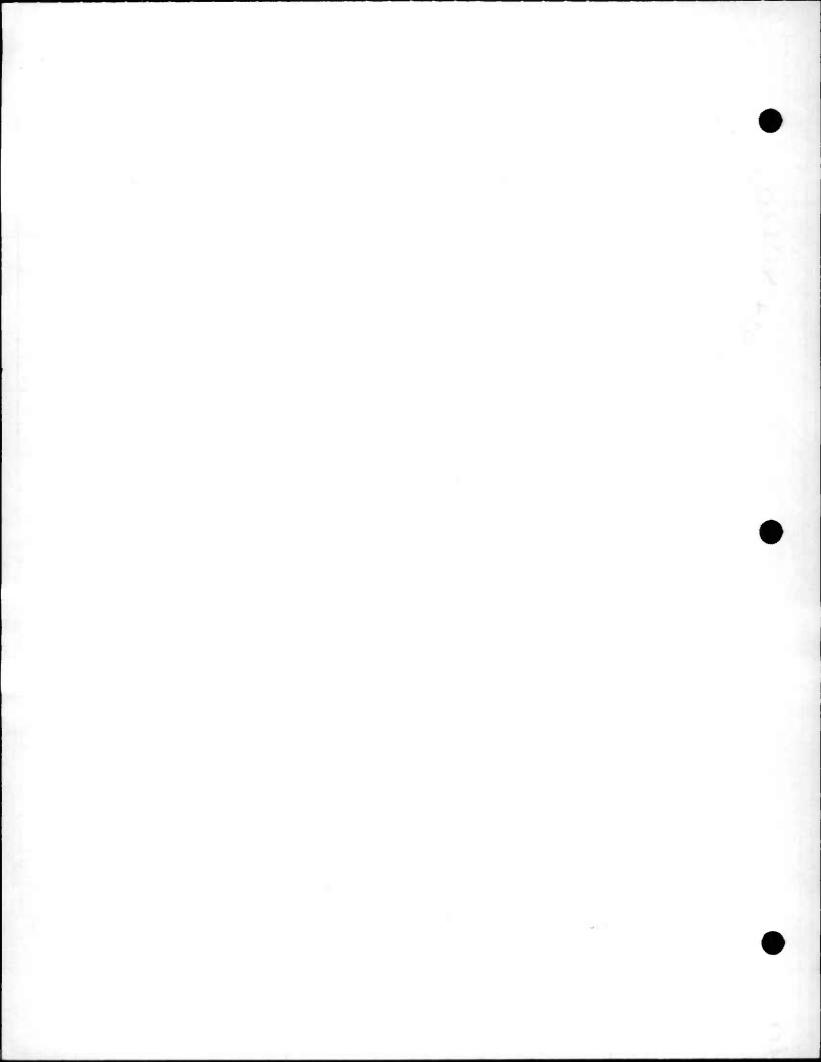
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FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH 1995 Catherine Doel1 July 08:50 A Gertrude 31 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. Nov 28, 216-03-8211 1 M 2 X F 86 Maryland burial-transit permit. Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Greater Baltimore Medical Center Towson Baltimore RESIDENCE OF DECEDENT 10a. STATE tob. COUNTY 10c. CITY, TOWN OR LOCATION tod. INSIDE CITY Maryland N/A Baltimore City 1 X YES 2 NO 10a. STREET AND NUMBER FUNERAL 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5300 Hamlet Avenue 21214 United States hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, Whits, stc. 1 X Never Married 2 Married В 1 YES 2 X NO Specify: Specify: 3 Widowed 4 Divorced page 5 should be detached for use as the White COMPLETED 15. OECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elamentary/Secondary (0-12) College (1-4 or 5+) Bookkeeper **Furniture** ONCE. 17. FATHER'S NAME (First, Middle, Last) ts. MOTHER'S NAME (First, Middle, Maiden Surname) William H. Doell notified at Margaret W. Roth BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Gertrude C. Lee 135 E. Timonium Road Timonium, Md. 21093 9 20a. METHOD OF DISPOSITION
1 X Burlal 2 Cremation 3 Rsm.
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must filled in by the funeral director, oudon Park Cem. 8/5/95 Baltimore Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. Milton Knight Jr 5305 Harford Rd. Baltimore, Md. 21214 other traumatic event, the medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or reepiretory arrest, Approximate shock, or heart fellure. List only one cause on cremation, or Interval Between Onset end Death IMMEDIATE CAUSE (Finel disease or condition resulting in death) CUTE has been signed by the attending physician and completely Dept. of Health and Mental Hygiene prior to burial, crematic executed MEDICAL CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) If any, leeding to immediate cause. Enter UNDERLYING 2 WARIAM death certificate CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF) that initieted events resulting in deeth) LAST 0 PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? CONCESTIVE Hemr shows any 1 TYES 2 NO OR ATTENDING PHYSICIAN: The law requires Mul 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO LUNCERTAIN Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) THE HOSPITAL OR ATTENDING PHYSICIAN: The THE FUNERAL DIRECTOR: After this certificate hiled within 72 hours after death with the State I HOSPITAL 1 YES 2 XNO inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) marked, 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED Natural 1 YES 2 NO BY Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) .09 COMPLETED 8 Could not be 4 Homicide 500 detarmined item 29s. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner se stated. IMPORTANT: IL MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and piecs, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CURTIFIE BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 223 2 30. NAME AND ADDRESS OF PERSON YHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sermis 1205 MONI STATEGISTPAPS SON TUR 31. DATE FILED (Month.)

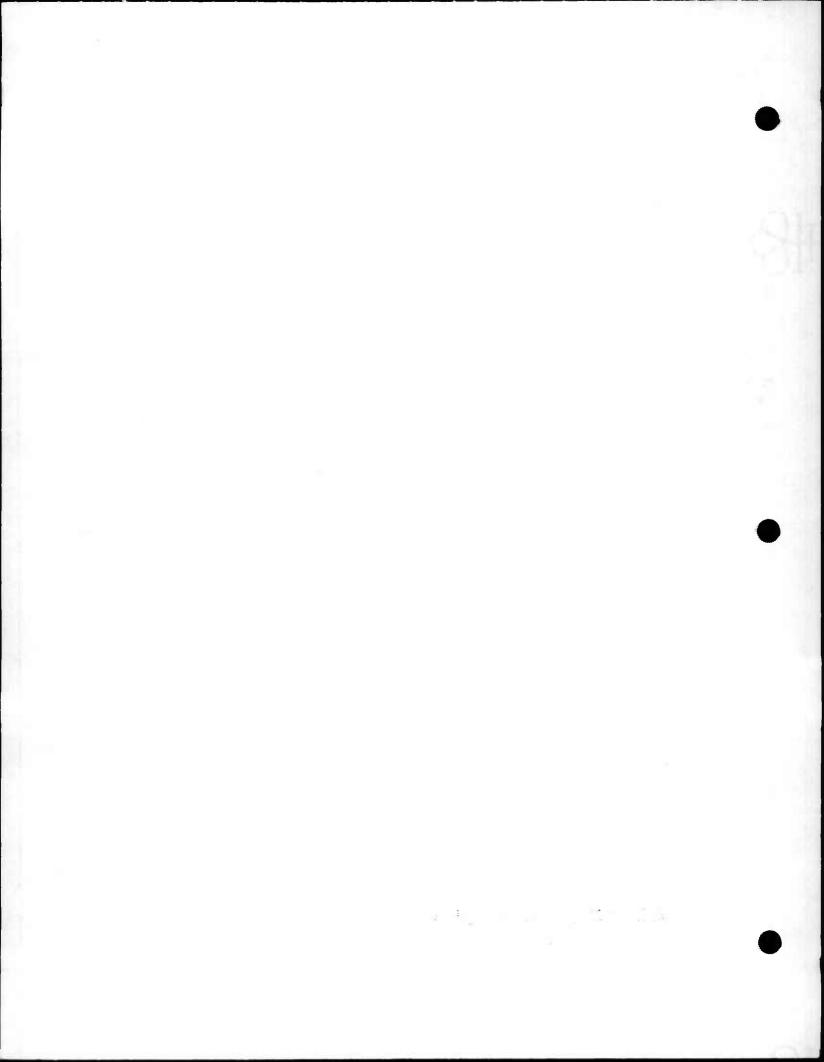
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ref hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, be filled within 72 buris after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

FOR STATE	STATE OF MARYL	AND / DEDAD	TRICKT OF U	PAITH ASID							
REGISTRAR		CERTIF	CATE OF	DEATH	MENTAL HYGIEN REG. NO						
1. DECEDENT'S NAME (First, Middle, Last)	5			<u> </u>	2. DATE OF DEATH	-	3. TIME OF DEATH				
JOAN C	- DOL	no			Lula 3		ST 7.115				
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Fore				
128-20-6960	1 M 2 KF	66 YRS.	MONTHS DAYS	HOURS MIN.	APR. 15. 1	929 1	Vew York				
9a. FACILITY NAME (If not institution, give at	reet and number)		9b. CITY, TOWN C	OR LOCATION OF D			Y OF DEATH				
Howard County G	eneral Hospi	tal	Columb	ia		Howar	rd				
RESIDENCE OF DECEDENT											
	d			TON			10d, INSIDE CITY LIMITS?				
	oward	E.		TID 0000			1 YES 2X N				
	Dlvd Lot	0.1				- 10 VA	N OF WHAT COUNTRY?				
11. MARITAL STATUS	12. WAS DECEDENT EVER II	NIIS ADMED					JSA				
1 X Never Married 2 Married	FORCES? 1 YES	2 Y 140	It yes, spi	ecify Cuban, Maxic	en, Puerto Ricen, etc.)	or No- 14	I. RACE — American Indian Black, White, atc.				
3 Widowed 4 Divorced	IF YES, GIVE WAN ON D	ATES	1 - YES	2 NO Speci	fy:		specify: White				
15. OECEDENT'S EDUC	ATION	16a. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF BUS	SINESS/INDUS					
Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	ork done during mo: e retired.)	st of working							
12	N/A	Assist	tant Eng	ineer	New York	Teler	hone Compar				
				18. MOTHER'S NA	AME (First, Middle, Maiden	Sumame)					
Martin A. Dolan											
							ode)				
Catherine Monville 6636 Washington Blvd., Elkridge, Md. 21227											
20a. METHOD OF DISPOSITION 20b. PLACE AND OATE OF DISPOSITION / Name of 20c. LOCATION — City or Town, State											
4 Donation 6 Dehen (Specify) Pineland Cemetery //31 Flushing, New York											
21. SIGNATURE OF FUNETAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc.											
5695 Main St., Elkridge, Md. 21227											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO OR AS A	CONSEQUENCE OF):				Oneet and I				
PART II. Other significant conditions	contributing to death b	ut not resulting in	the underlying	cause given in			24b. WERE AUTOPSY FIND AVAILABLE PRIOR TO				
					1 _ YES 2	DENO	COMPLETION OF CAL OF DEATH?				
					_		1 TYES 2 THE				
				UNCERTAI	N 🗆 📗						
EXAMINER?	HQSPITAL:										
27. MANNER OF DEATH		atient 3 DOA	4 - Nursing Home								
1 Natural 5 Pending	(Month, Day, Year)	28b. TIME INJU	IRY WO	RK?	28d. DESCRIBE HOW IN	JURY OCCUP	RED				
2 Accident Investigation	250 PLACE OF BUILDIN	***		ES 2 NO							
2 Accident 3 Suicide 4 Homicide Could not be determined 26a. PLACE OF INJURY — At home, tarm, street, factory, office building, atc. (Specify) 29a. CERTIFIER (Check only one) 29b. CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated one one of the cause of the cause of the cause of the cause of the time, data and place, and due to the cause of the time, data and place, and due to the cause of the time, data and place, and due to the cause of the time, data and place, and due to the cause of the time, data and place, and due to the cause of the time, data and place, and due to the time, data and place, and due to the time, data and place, and due to the time, data and place, and due to the time, data and place, and due to the time, data and place, and due to the time, data and place, and due to the time, data and place, and due to the time, data and place and place, and due to the time, data and place a							Rural Route Number,				
O COURT HOLDS	building, atc. (Spec	4 Homicide determined									
4 Homicide determined	building, atc. (Spec		7.0								
4 Homicide determined 29a. CERTIFIER (Check only	IAN: To the best of my knowl	edge, death occurred									
29a. CERTIFIER (Check only one) 29 MEDICAL EXAMINER	building, atc. (Spec	edge, death occurred									
4 Homicide determined 29a. CERTIFIER (Check only	IAN: To the best of my knowl	edge, death occurred			time, data and place, and	due to the c					
4 Homicide determined 299. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 299. SIGNATURE AND TITLE OF EXAMINER	IAN: To the best of my knowl On the besis of exemination	edge, death occurred	, In my opinion, de	29c. LICENSE NUI	time, data and place, and	due to the c	ause(s) and menner as atat				
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1 1 214 2 3 4 4 6 1 6 6 1 6 6 1	128-20-6960 98. FACILITY NAME (If not institution, give at HOWARD COUNTY GOOD COUNTY GOOD COUNTY Md. 108. STATE 108. COUNTY Md. 108. STATE 108. COUNTY Md. 109. STATE 108. COUNTY Md. 109. STATE 108. COUNTY Md. 11. MARITAL STATUS 1 Married 2 Married 3 Married 2 Married 3 Married 15. OECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last) Martin A. Dolan 199. INFORMANT'S NAME (Typa/Print) Catherine Monvil Catherine	128-20-6960 1	128-20-6960 1 M 2 F 66 YRS. 9a. FACILITY NAME (If not institution, give street and number) HOWARD COUNTY General Hospital RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Md. HOWARD 10c. STATE 10b. COUNTY Md. HOWARD 10c. STATE 10b. COUNTY Md. HOWARD 10c. STATE 10b. COUNTY Md. HOWARD 10c. STATE 10b. COUNTY Md. HOWARD 10c. STATE 10b. COUNTY Md. HOWARD 10c. STATE 10b. COUNTY Md. HOWARD 10c. STATE 10b. COUNTY Md. HOWARD 10c. STATE 10b. COUNTY Md. HOWARD 10c. STATE 10b. COUNTY Md. HOWARD 10c. STATE 10b. COUNTY Md. HOWARD 11c. MAS DECEDENT EVER IN U.S. ARMED FORCES? 1 1 YES 2 Y No If YES, GIVE WAR OR DATES (Give Man Or DATES) 10c. DECEDENT'S 10c.	128-20-6960 1 M 2 K 66 YRS. WONTHS DAYS 98. FACILITY NAME (If not institution, give street and number) HOWARD COUNTY General Hospital 100. STATE 100. COUNTY Md. HOWARD 100. STATE 100. COUNTY Md. HOWARD 100. STATE 100. COUNTY Md. HOWARD 100. STATE 100. COUNTY HOWARD 100. STATE 100. COUNTY Md. HOWARD 100. STATE 100. COUNTY HOWARD 100. STATE 100. COUNTY HOWARD 100. STATE 100. COUNTY HOWARD 100. STATE 100. COUNTY HOWARD 100. STATE 100. COUNTY HOWARD 100. STATE 100. COUNTY HOWARD 100. STATE 100. COUNTY HOWARD 100. STATE 100. COUNTY HOWARD 100. CITY, TOWN OR LOCAL Elkridge 100. CITY, TOWN OR LOCAL For Cert in Institute In Institution 100. CITY, TOWN OR LOCAL For Cert in Institute Institute In Institute In Institute In Institute In Institute Institute In Institute Institute In Institute Institute Institute Institute Institute Institute Institute Institute Institute Inst	128-20-6960 1	128-20-6960 1	128-20-6960 1				



BALTIMORE, MARYLAND 21215-0020	I nouns after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ith the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed when a main after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPAR CERTIF	RTMENT OF I	HEALTH AND		HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATH		3. T	IME OF DE	ATH
- 6	Stefanie Mari	e Feuer				July	28.	1995	EAR	6:06	Ам
	4. SOCIAL SECURITY NUMBER 5		n yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF	BIRTH	100	BIRTHPLAC		
	097-72-0038		8 YRS.	MONTHS DAYS	HOURS MIN.	Oct.	2. 19	86 G	Country) erman		
1 8	9a. FACILITY NAME (If not institution, give stree	it and number)		9b. CITY, TOWN	OR LOCATION OF D			9c. COUNTY		-	
S.	Mt. Washington Ped	iatric Hosp	ital	Ralti	more City	17	J	N/A			
ځ	Mt. Washington Ped					<u> </u>	1	IV/ E	1		
DIRECTOR				Y, TOWN OR LOCA	TION				10d.	INSIDE CI	TY
	New York Queen	.S	Ba	ayside						LIMITS? YES 2 (
RA		4.		10	f. ZIP CODE			10g. CITIZEN	OF WHAT	COUNTRY	?
FUNERAL	07 11 00100 00100				11361			USA			
5	1 X Never Married 2 Married	2. WAS DECEDENT EVER IN FORCES? 1 YES	2X NO	If yes, sp	ENDENT OF HISPAI ecify Cuban, Maxica	in, Puerto Rici	Specify Yea (in, atc.)	or No- 14.	RACE - A Black, Wh	merican in	dlan,
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TE\$	1 TYES	2X NO Specif	y:			Specify: Ta	Vhite	
	15. DECEDENT'S EDUCAT	TION	16a. DECEDENT'S	USUAL OCCUPATION	ON	16h KI	ND OF BUSI	NESS/INDUST		VIIICE	
ETI	(Specify only highest grade cor Elementary/Secondary (0-12)	mpleted) College (1-4 or 5+)	(Give kind of a	work done during me	ast of working	1.02.10	0. 000.	112371112031			
PL	N/A	55,000	ì	N/A		- 1	N	I/A			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Mick	dle, Maiden S	'umame)			
BE C	S Alan A. Feuer				Pia B	. Mart	in				
TO B	19a. INFORMANT'S NAME (Type/Print)		19b, MAILING	ADDRESS (Street a	and Number or Rural			State, Zip Coo	de)		
ř	Pia Conley		9189 N	Miller R	oad, Ft.	Belvo	ir, V	A 220	060		
	20a. METHOD OF DISPOSITION 1 Duriat 2 Coremation 3 Remova	20b.	PLACE AND DATE	OF DISPOSITION (No	me of			ATION — City		itate	
	4 Donation 5 Dather (Specify)	Ev	erly Cre	thar place) ematory	07	/31/95	Alex	andria	a, Vi	rgin	ia
	21. SIGNATURE OF THERAX BERVICE LICEN	GEE)		22. NAME A	on Park	CILITY					
	1612 > 1	1111			Wilkens				wo 1/	m o	1220
	23. PART I. Enter the diseases, pr com	nplications that caused	the death. Do r	opt anter the mo	de of dving, suc	h as cardia	or respir	TC TIIIO	Le, M	Approxi	1229
	snock, or heart failure. Lis	it Dnly Dna cause Dn aa	ch lina.		-c s - cymg, sac	ii aa oaraia	o o roupin	atory arrest	'	interval	Between
	iMMEDIATE CAUSE (Final disease or condition	To see 2 - 1 11-		-1 ****	.1						nd Death
	resulting in death) a	Terminal Hy	CONSEQUENCE OF	atus Wil	n non-ru	inctio	ning	VP shu	int	June	1994
z		Diabetes In	nsipidus	,					į	Jan.	1988
은	Sequentially list conditions, if any, laading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	F):							1,00
S	CAUSE (Disease pr injury	Adrenal Ins								Jan.	1988
	that initiated eventa resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	F):							
CERTIFICATION	d										
	PART II. Other significant conditions of	contributing to death but	it not resulting i	in the underlying	cause given in	Part i. 24	a. WAS AN A	LITOPSY	24h WER	E AUTOPSY	EIMPINGS
CAL	Mental Retardat				12 (217)		PERFORM	IED?	AWAJI	LABLE PRIO	R TO
	Severe Spastic		ia			- 1	YES 2	Х но	OF D	EATH?	
2	DID TOBACCO USE CONTRIB			S D NO D	UNCERTAI				1 []	YES 2	NO NO
AN	25. WAS CASE REFERRED TO MEDICAL			TH (Check only one)	UNCERIAII	<u>ч </u>					
PHYSICIAN: MED		IOSPITAL:	tiont 3 🗆 DOA	OTHER:	. In Classica	a [] au					
Ħ	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIM		e 5 🗆 Residence			JURY OCCUR	FD		
	1 X Netural 5 Pending	(Month, Day, Year)		URY WO	RK? YES 2 NO			000011			. 1
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY	— At home, farm, s		17	28f. LOCATIO	ON (Street an	d Number or F	tural Route I	Number.	
E	4 Homicide determined	building, atc. (Specif	(y)			City or 1	own, State)				
COMPLETED	29a. CERTIFIER Check only	N: To the best of my knowle	dos desth occurs	ed at the time, date	and place and due	to the source	->				-
ME	(Check only one) 2 MEDICAL EXAMINER: C	On the beele of examination	and/or investigatio	n, in my opinion, d	eath occured at the	time, date an	e) end mann d place, and	er se stated.	use(s) and	mannar aa	eteted
	29b, SIGNATURE AND THLE OF CERTIFIER	1									
B		1			29c. LICENSE NUI D43596	MISEM		29d. DATE SIG	,		
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEA	TH (ITEM 27) /7/04	Print)				- Jul	y 28	, 199	15
	Mark Redding	1708 W. Rog			timore,	MD 2	1209				
		26 CESTIFICATION	TUPE	iiuc nal	. C. Luiot E ,	<i>LLU</i> 2.	1207			_	\longrightarrow
	AUG 0 2 1995	A STATE OF THE PARTY									l

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

		REGISTRAR			CERTIF	ICA	IE OF	- DEAI	H		REG. NO.			
		1. DECEDENT'S NAME (First, Middle, La								2. DATE OF		Y 1	EAR .	. TIME OF DEATH
		BENJAMIN		GRA						MOHETH	LY	28 1	995	7:50A
		4. SOCIAL SECURITY NUMBER	5. SEX		vs. lest birthday)	# UNI	DER 1 YEAR	IF UNDER	24 HPIS.	7. DATE OF (Month, D	BIRTH	0	. BIRTHPI Country)	LACE (State or Foreign
D	- 0	217-32-9192	1 🔀 M 2 🗆 F	88	YRS.	IIIOW111	UATS.	noons	more.		22	1907	m	
3 should		9a. FACILITY NAME (If not institution, gh	e atreet end number)			9b. C	ITY, TOWN	OR LOCATIO	N OF DE	ATH		9c. COUNT	Y OF DEA	
2,3	8	1222 WINSTON	AVE				BAL	_T0				N//	4	
~"	ַ ט	RESIDENCE OF DECEDENT 10a, STATE 10b, COU									-			
the burial-transit permit. Pages	DIRECTOR	MD MD	N/A				N OR LOCA	ATION						IOd. INSIDE CITY
ii.			N/A			BAI	110							YES 2 NO
De la	FUNERAL	10e. STREET AND NUMBER					-10	of. ZIP CODE				10g. CITIZE	N OF WH	IAT COUNTRY?
ansit	ij.	1222 WINSTON	AVE					21:	239			U	.S.	Α.
nial-tr	5	11. MARITAL STATUS	12. WAS DECEDEN' FORCES? 1	EVER IN U.	S, ARMED		3. WAS DE	CENDENT O	F HISPAN	C ORIGIN?	Specify Yea	or No- 14	RACE -	- American Indien, White, etc.
Z E	BY I	1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE W				1 🗀 YE	S 2 XNO	Specify:	, Puerto Hici	en, etc.j		Specify:	
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ğ	삘	Elementary/Secondary (0-12)	College (1-4 or 5 +)	IIIe. Do NOT u		•			1				
ched	COMPL	7TH	N/A		BA	RBE	ER				BAF	RBER	SHO	Ρ
be detact at once.	응	17. FATHER'S NAME (First, Middle, Last)								ME (First, Mide		Sumame)		
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5 should notified	0	19e. INFORMANT'S NAME (Type/Print)										n, State, Zip Co		
le 5	-	CURLEY GRA	/ES		368	6 F	ORE	ST H	ILL	RD B	ALTO	, MD		21207
director, page er must be	1	209 METHOD OF DISPOSITION 1 A Burlel 2 Cremetion 3 R			ACE AND DATE					OATE	20c. LO	CATION - CIT	y or Town	n, Steta
must	- 1	Donation 5 Other (Specify)	imovat from State	Ar	butus	ther place	m Pa	ark		8395	Ar	butus	s . 1	1d
al dir		21. SIGNATURE OF FUNERAL SERVICE	LICENSEE					ND ADDRES		7	1		7	
e funeral di I. examiner		M111-1	1.0	- , 7	10		MAR	CH E	/ H - W	EST	430	O WA	BASI	HAVE
the oval.		23 PART Fater the disease or complications that according to the disease of the d												
filled in by the funeral on, or removal. he medical examin		23. PART I Enter the diseases, of shock, or heart failur	r complications that e. List only one cau	caused th	e death. Do	not ent	lar tha m	oda of dyli	ng, such	as cardia	c or respi	ratory arree	t,	Approximata interval Batween
n, or		IMMEDIATE CAUSE (FINA												Onest and Death
ely fille nation, t, the		disease or condition resulting in death)	1c	on	05/20	le	Car	1000	-			15 us ato		
completely fal, cremati event, t		disease or condition a. mctostatic prostole cancer 5 ye Due to (or as a consequence fr):										2 1000		
nd completely fille burial, cremation, atic event, the	z	- 												
6 0 E	임	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):												
the attending physician Mental Hygiene prior to njury, or other traun	8	S ceuse. Enter UNDERLYING												
ending phy I Hygiene p or other	뜨	that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
Hyg or o	EH	resulting in deeth) LAST												
e att	0	u.												
ed by the att th and Menta any injury,	EDICAL	PART II. Other aigniticant conditi	not resulting in the underlying cause given in Pa					art I. 24s. WAS AN AUTOPSY 24b				VERE AUTOPSY FINDINGS WAILABLE PRIOR TO		
	8								YES 2	NÃO		OMPLETION OF CAUSE OF DEATH?		
f Heal	¥					1 YES 2 WAO OF					TYES 2 THE			
certificate has been in the State Dept. of h		DID TOBACCO USE CON	ITRIBUTE TO CA	USE OF I	DEATH YI	S 🗆	NO [UNC	ERTAIN					
te De	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26.	PLACE OF OEA	TH (Che	ck only one)						
Star	Sic	1 TES 2 NO	HOSPITAL:	ER/Outpatie	nt 3 🗆 DOA	OTH	ER: luming Ho	ma 5 Rec	sidence 8	Other /S	inecify)			
th the	H	27. MANNER OF DEATH	28e. DATE OF		28b. TIN	E OF	28c. IN	JURY AT				JURY OCCUI	REO	
fter this c eath with marked,	ΥP	1 Natural 5 Pending	(Month, Da	y, rear)	IN.	JURY		ORK? YES 2 🗌	NO					
< 6 ₩	D BY	2 Accident Investigation 3 Suicide 6 Could not I	26a. PLACE OF	INJURY -	At home, ferm,	street, f	ectory, offi	ce		28f. LOCATI	ON (Street e	nd Number or	Rural Roi	ite Number
28 afte	ш	4 Homicide determined	building,	etc. (Specify)					1	City or 1	lown, State)			,
DIRECTOR: hours after item 28 i	MPLE	29e. CERTIFIER	Marine a local del Co					Constant		-110-02-1				
4 2 E	MP		SICIAN: To the best of											
INT.	S	2 MEDICAL EXAM	NER: On the bests of ax	amination an	id/or investigatio	on, in m	y opinion,	death occure	d at the t	lme, dete en	d place, and	d due to the o	:euse(e) e	and menner as stated.
ed w	w	29b. SIGNATURE AND TITLE OF CERTIF	WER					29c. LICE	NSE NUM	BER		29d. DATE S	IGNED (A	Aonth, Day, Year)
TO THE FUNERAL be filed within 72 t IMPORTANT: If I	8 0	360011	133	_	M.D.			164	150			D 71	128	195
	F	MANUE AND ADDRESS OF PERSON	WHO COMPLETED CAUS	E OF DEATH	(ITEM 27) (Type	, Print)		*				- (- 4	
		Elliott N. Exa	T MD	600	on. a	10/	E 1	54	Bok	5000	WN	21	205	_
		31. DATE FILEO (Month, Day, Year)	32. REGISTRAI	R'S SIGNATU	RE	٠, ٠		, , ,		1	-11/2			
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

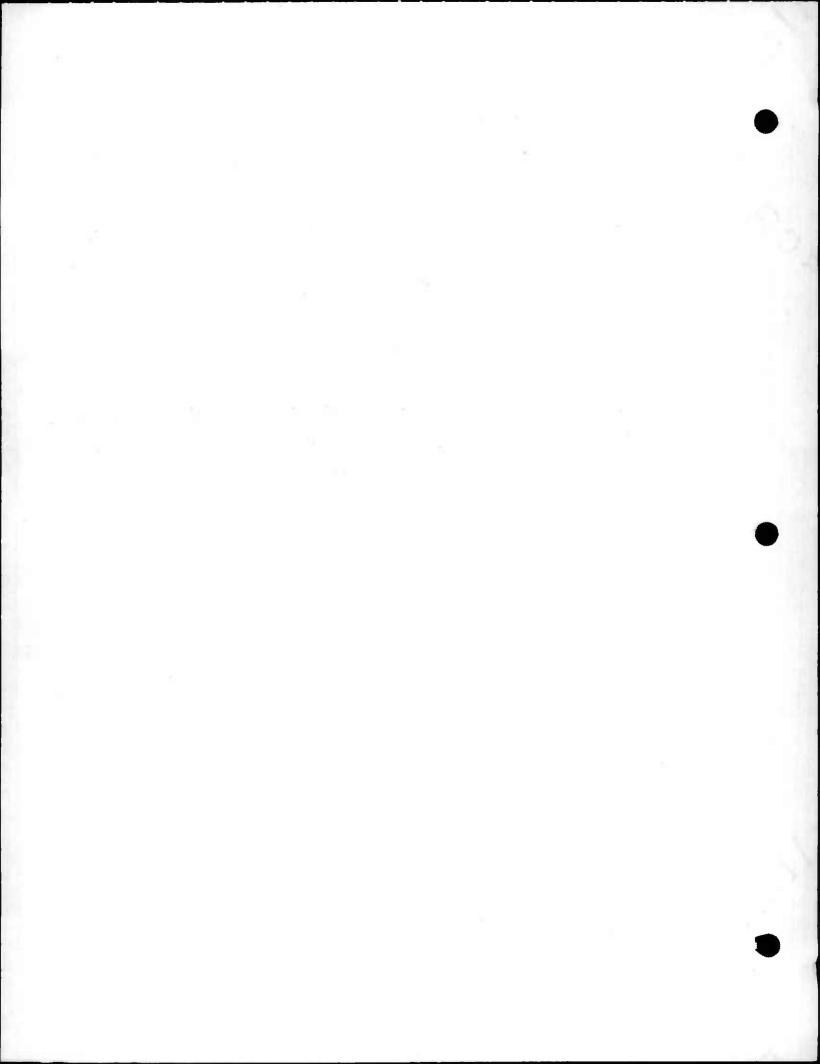
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IE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed withing thospital or attending physician.	E FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1		
by the hospital	d be detached for		
s may be retained	tor, page 5 should		not be notified
fter death. Page 6	the funeral direct	oval.	STATES IN the State SO In security on these SS absence have been described about the security of the security
Athleses hours a	eletely filled in by	remation, or rem	- A Ab AT
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e death certifica	the attending phy	Mental Hygiene	inn or other
v requires that the	been signed by	t. of Health and	ahouse and le
YSICIAN: The lav	s certificate has	th the State Dep	nd or Ham 92
ATTENDING PH	RECTOR; After thi	is after death wi	m 90 In march
E HOSPITAL DF	E FUNERAL DIF	d within 72 hou	OTAMT. 16 16ac

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH RONALD JÜLŸ 31, Ï995 And GRIFFIN 5:45A M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR 8. BIRTNPLACE (State or Foreign 1 X M 2 🗆 F DAYS HOURS 220-18-874 -12-6 m 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY ma. SA/TO. YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 809 21205 U.S.A WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puarto Rican, etc.)
 I YES 2 NO Specify: 14. RACE 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION ecity only highest grade comple 18s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ndary (0-12) College (1-4 or 5+) 17. FATNEBIS NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden BE 19a. INFORMANT'S NAME (Type/Print) 2 A 20a. METHOD OF DISPOSITION
1 □ Burlal 2 Cremation 3 □ Ramoval Irom State 20b. PLACE AND DATE OF DISPOSITION (Name of Cremetory or other piece) 4 Donation 5 Other (Specify) FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 4,1 1129N. Auline 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, Approximete shock, or heert feliure. List only one ceuee on each line. Interval Between **IMMEDIATE CAUSE (Fine) Onset and Desth** disesse or condition TOXOPASMOSIS
DUE TO (OR AS A CONSEQUENCE OF): resulting in death) 3days RE-HOVIVAL ILLNESS
DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION loyears Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in deeth) LAST PART II. Other significent conditions contributing to death but not recuiting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 TES 2 NO 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) **EXAMINER?** HOSPITAL:
1 Minestent 2 - ER/Outpatient 3 - DOA OTHER:
4 □ Nursing Home 5 □ Residence 8 □ Other (Specify) 1 TES 2 10 27. MANNER OF DEATH 280. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — Al home, farm, streel, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 Nomicide 29a, CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER TO THE TO THE De filed BE 29d. DATE SIGNED (Month, Day, Year) ence Dreus Fer MD エフナイナ July 31, 1995 rewater Johns Hopkins Hospital Baltimore 2

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

Brey

AUG 0 2 1995

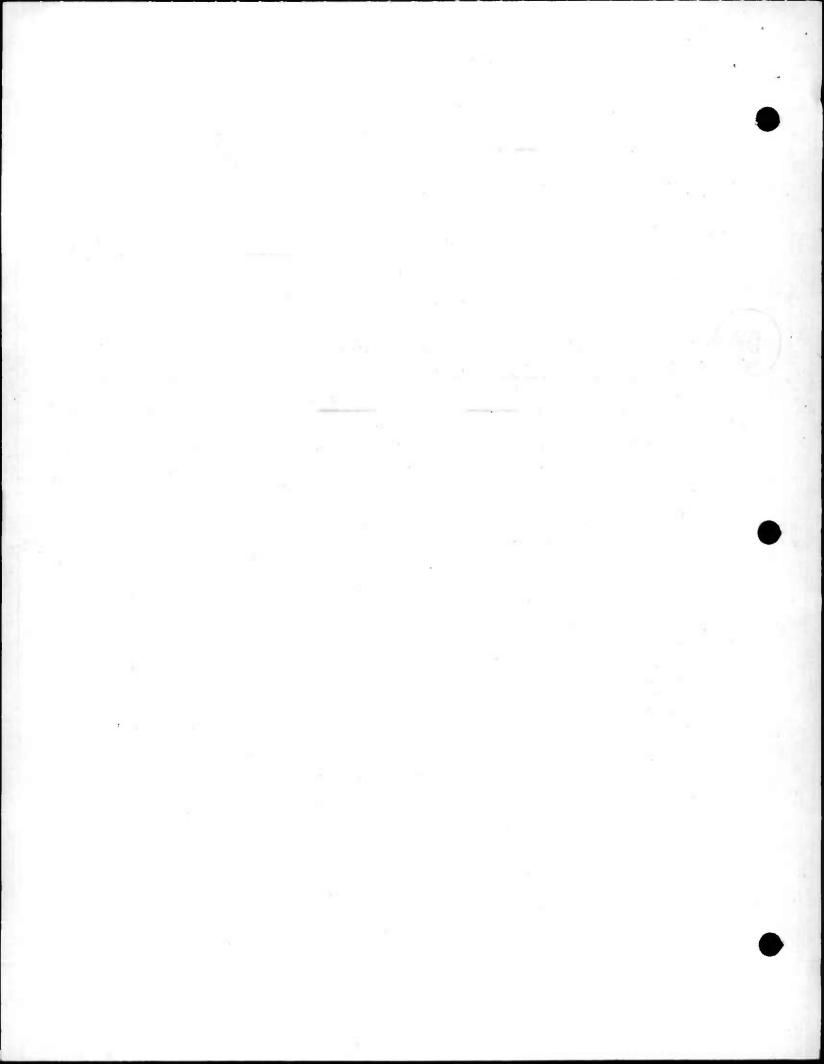


7	range.	Ħ	ļ
 TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should the filled within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at	
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OSP	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furbe filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal,	빏	
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10 T	TO The	를	
	- 23		

the burlat-transit permit, Pages 1, 2, 3 should

(5-0020

	1 - STATE REGISTRAR	STATE OF MAR	YLAND / DEPA CERTI					MENTAL HYG			
	1. DECEOENT'S NAME (First, Middle, Last) WILLE M.	HOLLE				<u>DE</u> RI		2. DATE OF DEAT		IQ VEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 245 – 52 – 6080		GE (In yrs. lest birthday	MONTHS	DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTY (Month, Day, Vo. FEB. 15,	M	6. BIRTH Count	IPLACE (State or Foreign
	9e. FACILITY NAME (If not institution, give :	street and number)		9b, CITY	r, TOWN C	R LOCATIO	N OF DE			OUNTY OF D	
OR		PITAL			BALT	IMORE		CITY		n/	a
E	RESIDENCE OF DECEDENT 100. STATE 10b. COUNT	γ	10c. C	ITY, TOWN	OR LOCAT	ION					10d. INSIDE CITY
DIRECTOR	MARYLAND	n/a				IMORE					LIMITS?
	10e. STREET AND NUMBER				101	. ZIP CODE			10g. C	ITIZEN OF	WHAT COUNTRY?
FUNERAL	2427 SEAMON	AVENUE				-2	122	21225	UN:	ITED	STATES
ВУ	11. MARITAL STATUS 1 Never Merried 2 Merried 3 XVIdowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR OF	ES 2 VINO		If yes, sp	ENDENT OF	F NISPAN I, Mexical Specify	IIC ORIGIN? (Special of the Control	fy Yee or No— c.)	14. RACI Black Spec	E — American Indian, k, White, etc. //y: BLACK
COMPLETED	15. DECEDENT'S EOU (Specify only highest grade Elementary/Secondary (0-12) 4 th	CATION completed) College (1-4 or 5 +)	III0. Do NOI	s usual of work done use retired.)	during mo	ON st of working	7		r BUSINESS/II		home
Š	17. FATNER'S NAME (First, Middle, Last)	Edward Brother				18. MOTN	ER'S NA	ME (First, Middle, Mi			
BEL	-EDWard b	rothers S	i R.			F	ROSA	BRINKL	EY.		
10	19a. INFORMANT'S NAME (Type/Print) WILHELMENI	Radford A RADFOE	19b. MAILIN	AODRES	s Mai			, BALTIN			AND 21212
	20a. METHOD OF DISPOSITION VIA Burial 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State	20b. PLACE AND DATE cemetery, crematory of MT . AUB	e of bispos other place)	SITION (Na	me of METER	Υ 8		e. LOCATION -		MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LIC		an A	22.	NAME AN	D ADDRES	S OF FAC				
	23. PART I. Enter the diseases, or	complications that cau	sed the deeth. Do	not enter	the mo	de of dylr	ng, auch	as cardiec or i	reapiratory a	rreat.	Approximata
	IMMEDIATE CAUSE (Final	Liet only one ceuse of	n eech line.								interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST	DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A DUE TO (OR A	S A CONSEQUENCE	FLF (y	Dise	ase.				
MEDICAL	PART II. Other significent condition SLPS 15	s contributing to deat	h but not resulting	In the ur	nderlylng	cause g	iven in i	PE	S AN AUTOPS REFORMED?	7 246	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 FANO
ž	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH Y	ES 🗆 I	NO 🗆	UNC	RTAIN				T TES 2 GPNO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DE	-							
PHYSICIAN:	1 TYES 2 NO	NZ Inpatient 2 ☐ ER/O	Outpetient 3 DOA	OTHER		5 🗆 Ree	Idence	6 Other (Specify)		
ву Рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJUF (Month, Day, Yea		ME OF JURY M	28c. INJI WO 1 _ Y	RK?	NO	26d. DESCRIBE N	O YRULNI WO	CCURED	
	3 Suicide 6 Could not be 4 Nomicide determined	28e. PLACE OF INJU- building, etc. (S	JRY — At home, farm Specify)	, alreet, fact	ory, office			281. LOCATION (St City or Town, S	treet and Numb Stete)	er or Rural F	loute Number,
COMPLETED		CIAN: To the best of my kn									
	29b. SIGNATURE AND TITLE OF CERTIFIER			1011, 111 my C	1						
TO BE	wennin e	hun	M.D.			AS 2	44 11	614-/12	29d. DA	Wig .	(Month, Day, Year) 28, (995
	30. NAME AND ADDRESS OF PERSON WH Wen-min Chuc		DEATN (ITEM 27) (Typ	300)	5.	Han	hux	, 34 ,	Bulha	me i	no Lech
	31. DATE FILED (AU Cov. 0°2 199	5 32. RESISTRANDA	GNATURE ROAD	4				/		1	



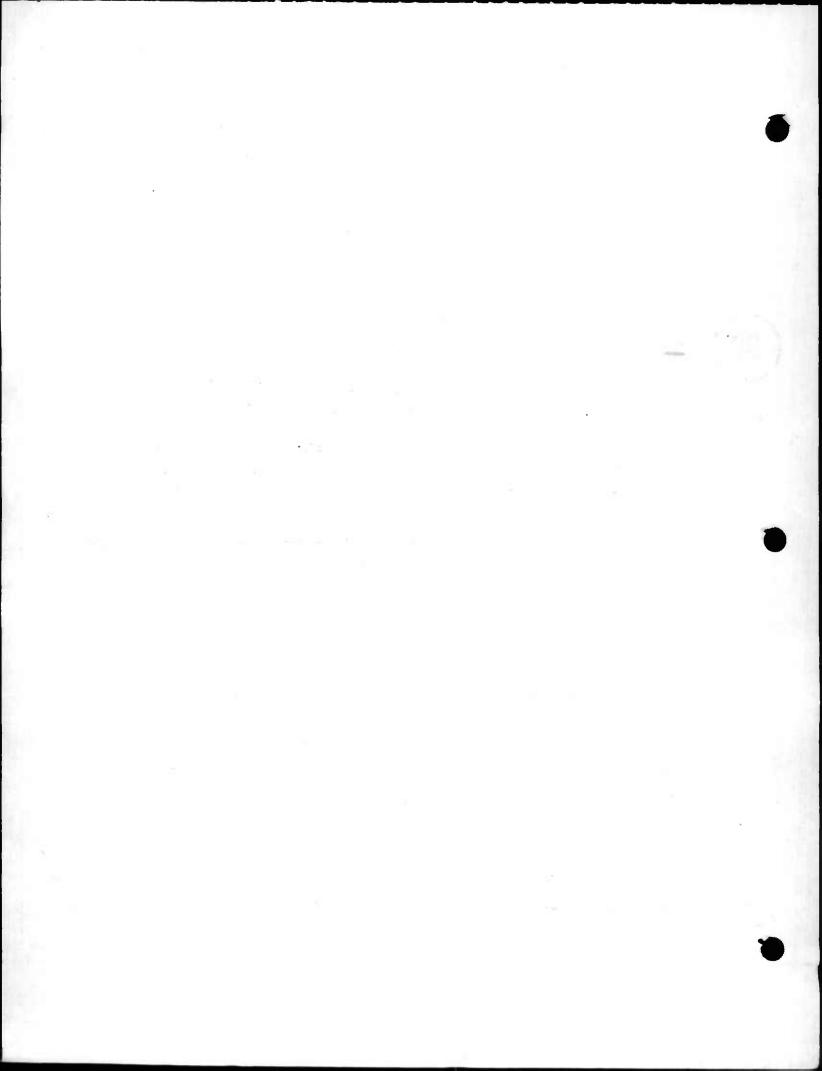
	1 - STATE REGISTRAR	DIALE OF MARTI		ICATE C	F DEATH	יי טוז. -	MENIAL HYGIEN REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DA	v	YEAR :	3. TIME OF DEATH
	MARCELLA H.	HYSER						, 199		4:00 P. M
			(In yrs. last birthday)	IF UNDER 1 YEA		HRS.	7. DATE OF BIRTH (Month, Day, Year)		Gountry)	LACE (State or Foreign
	212 22 7002		78 YRS.				AUG.1,1916		MAR	YLAND
DIRECTOR	9e. FACILITY NAME (If not institution, give street a 7141 FAIRBROOK ROAD	and number)			N OR LOCATION TIMORE	OF DE	ATH	9c. COUNT		LTIMORE
ᇤ	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CI1	Y, TOWN OR LO	CATION					10d, INSIDE CITY
E I	MARYLAND BA	LTIMORE			BALTIMO	RE				LIMITS?
	10e. STREET AND NUMBER				10f. ZIP CODE			10g. CITIZI	EN OF WE	HAT COUNTRY?
ER/	7141 FAIRBROOK ROAD				212	44			U.S.	Α.
BY FUNERAL	1 Never Married 2 Married	WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 X NO	II yes		Maxica	IIC ORIGIN? (Specify Yee n, Puarlo Rican, atc.)	or No-	14. RACE - Bleck, Specify	- American Indian, White, atc. WHITE
8	15. DECEDENT'S EDUCATIO (Specify only highest grade comp	ON plated?	16a. OECEOENT'S		ATION most of working		16b. KIND OF BUS	INESS/INDU	STRY	
E	Elementary/Secondary (0-12) Co	ollege (1-4 or 5+)	life. Do NOT u	ise retired.)	, most of working					
E	101)TH GRADE		HOMEMA	KER				AKING		
8	17. FATHER'S NAME (First, Middle, Leist) FRANK HELLWIG						ME (First, Middle, Meiden ES KABINSK			
то ве сомисетер	19a. INFORMANT'S NAME (Type/Print)		405 444 454						2 4 1	
2	MRS. FAITH SERIO						Route Number, City or Tow BALTIMORE			244
	204 METHOD OF DISPOSITION	20	b. PLACE AND DATE					CATION - C		
	1 XBurial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State	NEW CATHE	DERAL	CEMETER	Y		TIMOR		
	21. SIGNATURE OF FUNERAL SERVICE LICENSI						AL HOME, I	NIC.		
	Janie E X	11		1			AVENUE-BAL		E. M	D 21229
-	23. PART I. Enter the diseases, or comp	plicetions that cause	ed the dasth. Do							Approximata
- 1	shock, or heart fellure. List							_		Intarval Batwean Onset and Death
	diseese or condition resulting in death)	MAI DUE TO (OR AS	A CONSEQUENCE	7 L	4 up	40	ma			April 95
_										į
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE (OF):		•				
CA	CAUSE (Disease or injury									
	that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSEQUENCE (OF):						i 1
CEF	d									+
	PART II. Other algnificant conditions co						Demen.			WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DICAL	HYDERTONSIUE	Anton	coselo	rote	CARY	ale	2 1 TYES 2	NO		COMPLETION OF CAUSE OF DEATH?
ME		4579E.				-67	EE/S			1 TYES 2 NO
ä	DID TOBACCO USE CONTRIB	UTE TO CAUSE			_	RTAII	NO			
PHYSICIAN:		OSPITAL:	26. PLACE OF DEA					1 * 6 * 4 *	4/-	20145000
IYSI		inpetient 2 ER/Ou				denca				spites once
	27. MANNER OF DEATH 1 Matural 5 Pending	28e. OATE OF INJURY (Month, Day, Year)	10	IJURY	WORK?	100	28d. DEŞCRIBE HOW I	4	JHED	
ВУ	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF INJUR		- 1			28f. LOCATION (Street	•	or Rural Ác	oute Number.
COMPLETED	4 Homicide 6 Could not be	building, atc. (Sp					City or Town, State			
Ë	29a. CERTIFIER 1 CERTIFYING PHYSICIAN	N: To the best of my kno	wladge, death occur	red at the time.	data and place. a	and due	to the cause(a) and ma	nner as etate	d.	
MF	(Check only one) 2 MEDICAL EXAMINER: O									end manner es stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER				29c, LICEN	ISE NU	MBER	29d. DATE	SIGNED	(Month, Day, Year)
BE ((Paris	no s	M) ,		-	02	•	7-	31-95
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF C	DEATH (ITEM 27) (Typ	e, Print)						, ,-
	DR. ORLANDO B. CONA				- BALT	IMO	RE, MD	2120	7	
	31. DATE FILEO (MONTO 0 2 1995	Julia dies	MATURE RANDAL	ζ.						

BALTIMORE, MARYLA TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by TO THE FUNERAL DIFFCTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be to be field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at DIVISION OF VITAL RECORDS, P.O. BOX 68760

the burtal-transit permit. Pages 1, 2, 3 should

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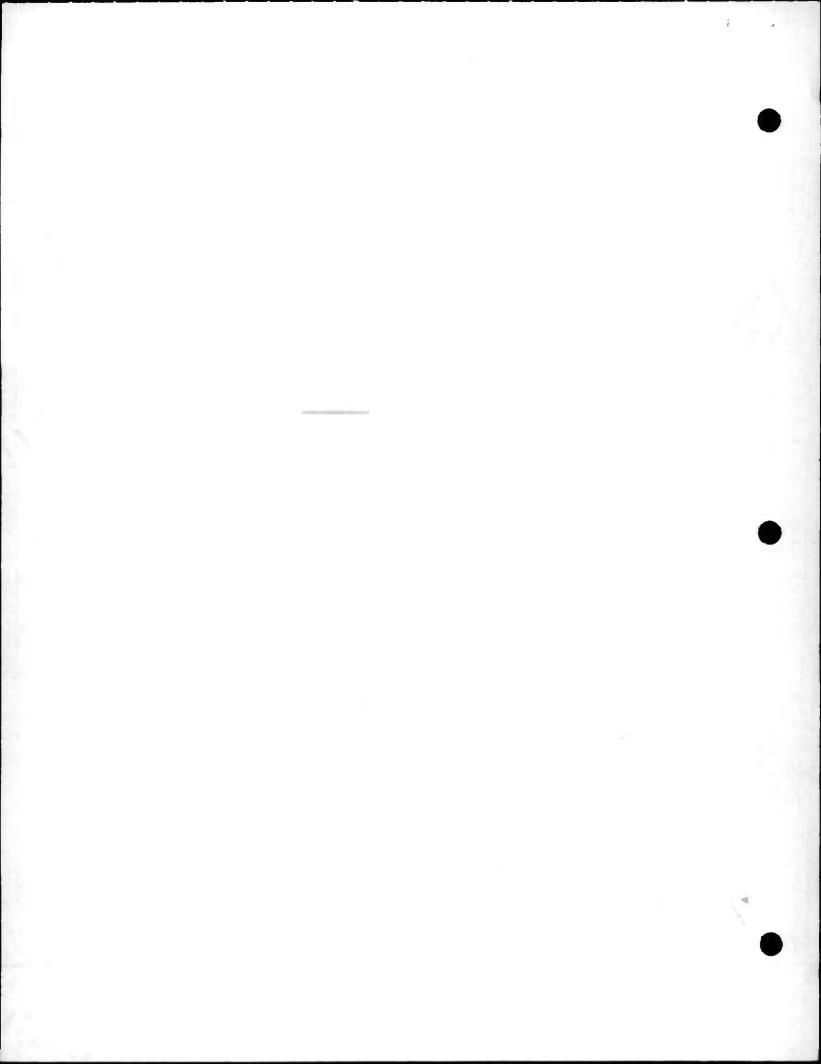
DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hounger TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be districted, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

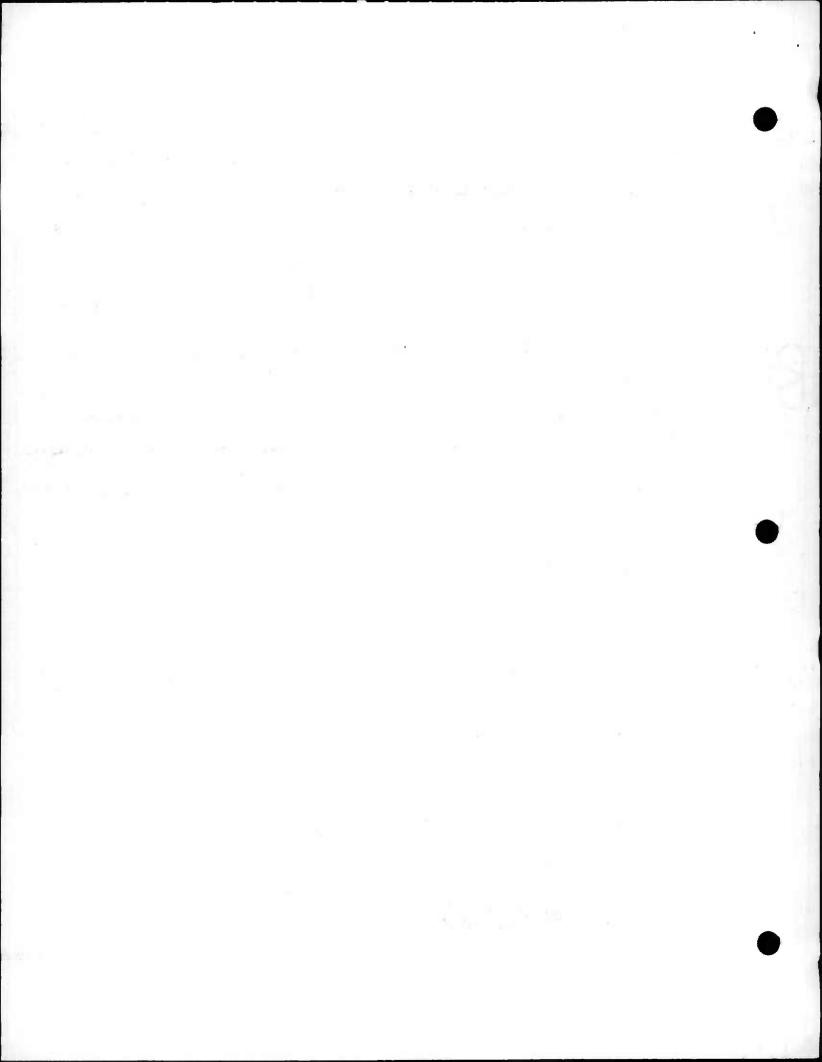
IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

transit permit. Pages 1, 2, 3 should

	1 - STATE REGISTRAR	STATE OF MARYLAND	DEPARTME	NT OF HEALTH AND	MENTAL HYGIEN	
	1. DECEDENT'S NAME (First, Middle, Last)	tardy			2. DATE OF DEATH DATE OF DATE OF DEATH DATE OF DAT	3. TIME OF DEATH
	24.4 44 474	5. SEX 8. AGE (In yrs. In		DER 1 YEAR IF UNDER 24 HRS. IS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	BIRTHPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not institution, give stree	/// J		CITY, TOWN OR LOCATION OF	MAY 9, 193	2 BALTIMORE, MD
DIRECTOR	JOSEPH RITCH	HIE HOSPICE		BALTIMORE	CITY	n/a
E E	10a. STATE 10b. COUNTY		10c. CITY, TOW	N OR LOCATION		10d. INSIDE CITY LIMITS?
	MARYLAND 100. STREET AND NUMBER	n/a		BALTIMORE 107. ZIP CODE		YES 2 □ NO
FUNERAL	2414 ASHLA	AND AVENUE			21205	UNITED STATES
M A	11. MARITAL STATUS 1 Never Married 2 XXMarried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. AI FORCES? 1 TYES 2 THE IF YES, GIVE WAR OR DATES	RMED	13. WAS DECENDENT OF HISP If yes, specify Cuban, Mexi- 1 YES 2 X XNO Specify	can, Puerto Rican, atc.)	or No.— 14. RACE — American Indian, Black, White, etc. Specify: BLACK
COMPLETED	15. DECEOENT'S EDUCAT (Specify only highest grade co.	ompleted) ((ECEDENT'S USUAL Give kind of work do	L OCCUPATION one during most of working od.)	The second second	MODE CITY
4	Elementary/Secondary (0-12) 6 th	College (1-4 or 5+)		AL MECHANIC	BALTI DEPT.	
	17. FATHER'S NAME (First, Middle, Last)	V 60		18. MOTHER'S N	AME (First, Middle, Maiden	Surname)
BE	WILLIAM HARDY 19a. INFORMANT'S NAME (Type/Print)		b. MAILING ADDR	ess Ashland or Burn	RUBY DESH I Route Number, City or Town	IELDS
2	CYNTHIA HARDY	Υ			ENUE, BALTI	
	20e, METHOD OF DISPOSITION 1 Description D		AND DATE OF DISI	POSITION (Name of	DATE 20c. LO	CATION — City or Town, State
	21. SIGNATURE OF FUNERAL BERVICE LICEN	KIN		ORIAL PARK 22. NAME AND ADDRESS OF I		ANDALLSTOWN, MD
	Minut	to B. Som		WM. C. M	ARCH FH1	101 E. NORTH AVENU
П	23. PART I. Enter the diseases, or con ehock, or heart fellure. Lis	mplications that caused the dest only one cause on each line	eeth. Do not en	ter the mode of dying, su	ch es cerdiec or reepi	ratory erreet, Approximate
	IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Lung Ca	nces			Interval Between Onset and Death
-		DUE TO OR AS A CONSE	OUENCE OF):			
TIO	Sequentially list conditions, if any, lesding to immediate	DUE TO (OR AS A CONSE	OUENCE OF):			
FICA	csuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A CONSE	OUENCE OF):			
CERTIFICATION	resulting in deeth) LAST					
CALC	PART II. Other significent conditions of	contributing to death but not	resulting in the	underlying ceuse given is		
DIC					PERFOR	COMPLETION OF CAUSE
: MEDI	DID TOBACCO USE CONTRIE	RUTE TO CAUSE OF DE	TU VEC	CNO C UNICERTA		1 UYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26. PLA	CE OF DEATH (Che			
YSIC	1 TES NO	HOSPITAL:		IER: Nursing Home 5 - Realdence	Other (Specify)	DSPICE
	27. MANNER OF DEATH 19 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW II	NJURY OCCURED
D BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY — At he building, etc. (Specify)	ome, farm, street, i		28t. LOCATION (Street a City or Town, State)	and Number or Rural Route Number,
ETE.	4 Homicide determined					
COMPLETE	(Check only T CEHTIFYING PHYSICIA	AN: To the best of my knowledge, do On the besis of examination and/or				oner as stated. d due to the ceuse(a) end manner as stated.
TO BE	2 SIGNATURE AND STYLE OF CERTIFIER			29c. LICENSE NO	327	29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year)
	Doors D. R. 6.	COMPLETED CAUSE OF DEATH (ITE	AMPA	E Oru	MEIA M	D 21045
	31. DATE FILED AUCON 0°2 1995	32. REGISTRAMS SIGNATURE	ardall			

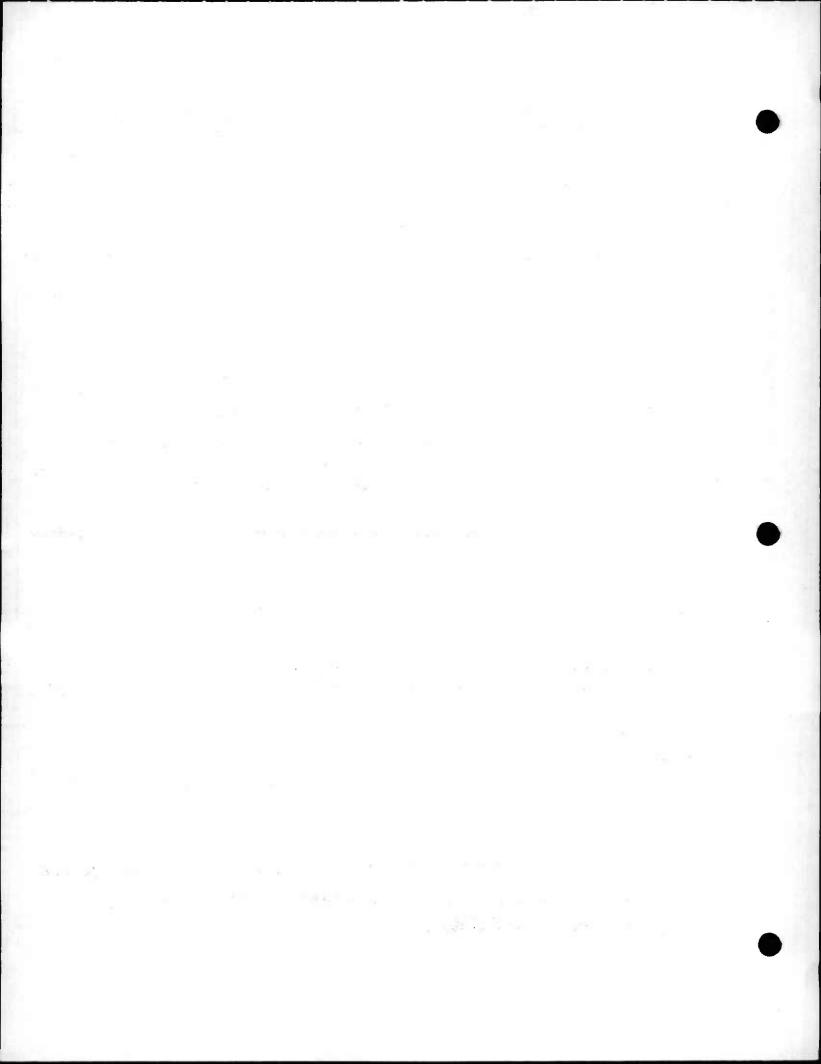


		1 - FOR STATE REGISTRAR	TE OF MARYLAND / DEPAR CERTIFI	TMENT OF HEALTH AND ICATE OF DEATH	MENTAL HYGIENE REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Lest)	BEST HADE	EY	2. DATE OF DEATH DAY	1995 523 P M
рir		201 00 2101 2	6. AGE (in yrs. last birthdey) 75 YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
1, 2, 3 should	CTOR	9a. FACILITY NAME (II not institution, give street and r	W HOTE TILL	96. CITY, TOWN OR LOCATION OF DE	EATH 9c. C	COUNTY OF DEATH HARFORD
Pages	DIRE	100. STATE 100. COUNTY OARYLAGO HARIE	10c. CITY	Y, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? 1 YES 2 NO
an. ransit permit.	FUNERAL	100. STREET AND NUMBER	DRIVE	101, ZIP CODE 21154	10g.	CITIZEN OF WHAT COUNTRY?
5-0020 nding physician. Is the bunal-transit	BY FUR	1 Never Married 2 Married FOR	DECEDENT EVER IN U.S. ARMED ICES? 12 YES 2 NO ES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPAF If yes, specify Cuban, Mexica 1 YES 2 NO Specify	in, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, stc. Specify:
21215 al or attend for use as	LETED	15. DECEDENT'S EOUCATION (Specify only highest grade completed Elementary/Secondary (0-12) College	16a. DECEDENT'S	USUAL OCCUPATION work done during most of working e retired.)	16b. KIND OF BUSINESS	INDUSTRY
LAND 2 the hospital detached for	COMPL	17. FATHER'S NAME (First, Middle, Last)	6. 12/13	R CARRIAR 16. MOTHER'S NA	ME (First, Middle, Meiden Surnam	ST OFFICE
MARYL retained by 5 should be notified at	TO BE	190, INFORMANT'S NAME (Type/Print)	AROLEY 196. MAILING	ADDRESS (Street and Number or Rural I	Route Number, City or Town, State,	B25T 210 COOO) &1154
AE, be page		20e. METHOD OF DISPOSITION DE Burlei 2 Cremetion 3 Removal from	20b. PLACE AND DATEO cametery, crematory or other		DATE 20c. LOCATION	— City or Town, State
death. Page 6 m death. Page 6 m e funeral director, I.		4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Wilkelite (22. NAME AND ADDRESS OF FA	15 FALLS	- BILAIR, P.A.
after after by the moval.	H	23. PART I. Enter the diseases, or complica shock, or heart failure. Liet only	ations that coused the death. Do n	30xwPcc0 of dying, such	DRIVE TOO	
within 24 to pletely fille cremation.		IMMEDIATE CAUSE (Final disease or condition resulting in death)	OUE TO (OR AS A CONSCOURAGE OF	Jaisens		Interval Between Onset end Death
OX 68/10 a be executed sician and cominor to burial, traumatic ev	TION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUENCE OF			
h certificate anding phys Hygiene p	ERTIFICATION	cause, Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST	OUE TO (OR AS A CONSEQUENCE OF):		
t the by the MA Mile	CAL CEI	PART II. Other significant conditions contrib	buting to death that not resulting in		Pert I. 24a, WAS AN AUTOP: PERFORMEO?	AVAILABLE PRIOR TO
) = 8 - E	MEDI				1 - YES 2 NO	COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN: The law certificate has but the State Dept.	SICIAN:	DID TOBACCO USE CONTRIBUTE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	28. PLACE OF DEATH	H (Check only one) OTHER:	A	V
NG PHYSICIA frer this certif eath with the marked, or	BY PHY	27. MANNER OF DEATH 26e	a. DATE OF INJURY (Month, Day, Year) 28b. TIME INJU		6 ☐ Other (Specify) 26d. DESCRIBE HOW INJURY	OCCURED
TTENDI TTOR: A after d	<u>a</u>		. PLACE OF INJURY — At home, farm, st building, atc. (Specify)	treet, factory, office	26f. LOCATION (Street and Num City or Town, State)	nber or Rural Route Number,
HOSPITAL OR A FUNERAL DIREC WITHIN 72 hours TANT: If item	COMPLET		the best of my knowledge, death occurred bests a minimation end/or investigation			
TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: If	O BE C	296 SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUM	18ER 29d. 0	DATE SIGNEO (Month, Day, Year)
17	ř	LINDA FACILI	CH 101 E	Print) Well Non	I Belant	4021015
		AUG 0 2 1995 Juli 2	REGISTRAR'S SIGNATURE			

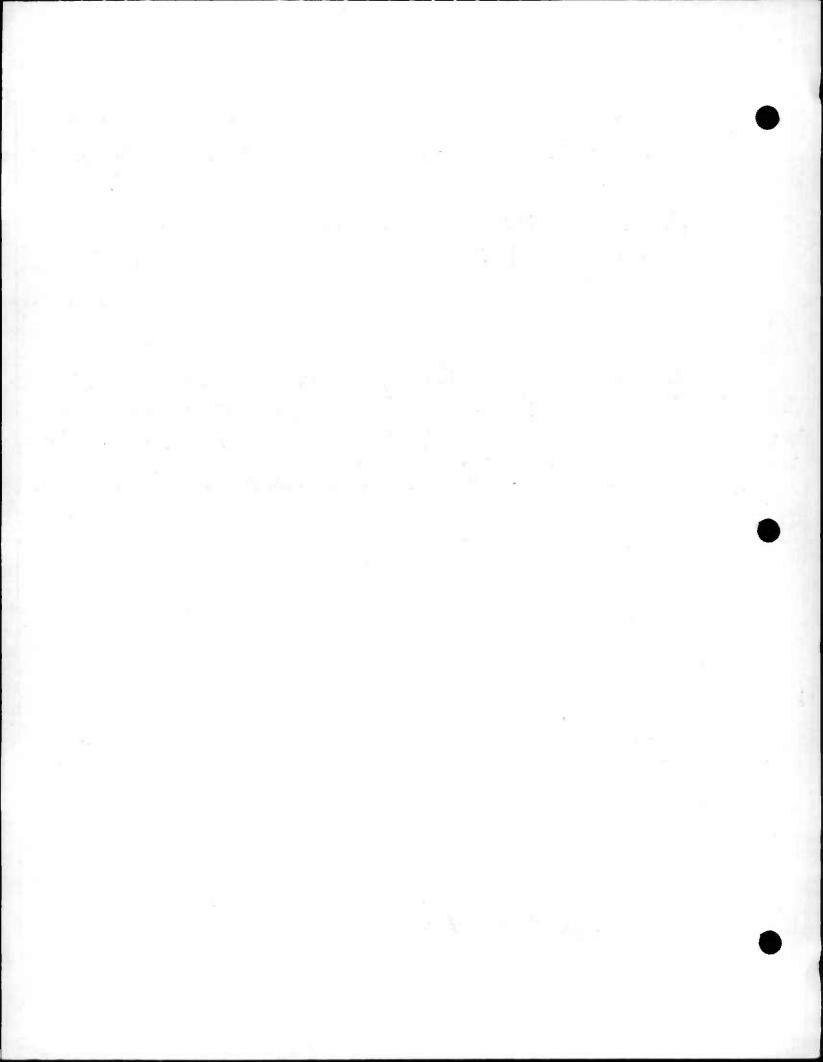


BALTIMORE, MARYLAND 21215-0020	shours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should thin the State Dept. of Health and Memal Hyglene prior to bunial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withmed hours after death. Page 6 may be retained by the hospital or attending physician.	I'ME FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	OFTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

		FOR		STATE OF M	IADVI AND	/ DEDAR	THENT OF				90	23	400
	_	1 - STATE REGISTRAR		SIMIE UF M			CATE OF	HEALTH AND DEATH	MEN I/	REG. NO.	E		
		1. DECEDENT'S NAME (First	, Middle, Last)	E 1/2		11-			2. DAT	E OF DEATH		YEAR	TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	BER	5. SEX	6. AGE (In yrs. In	ost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DAT	E OF BIRTH		95	CE (State or Foreign
9		213-03-7321		1 M 2 F	86	YRS.	MONTHS DAYS	HOURS MIN.		th, Day, Year) 2, 19		Country) Marvl	
3 should	oc	9a. FACILITY NAME (# not in		Carter - Confi				OR LOCATION OF D				Y OF DEAT	
1, 2,	CTO	St. Agnes H	OSPIT	al			Balti	more				N/A	
physician. burial-transit permit. Pages	DIRECTOR	10a. STATE	10b. COUNT				, TOWN OR LOCA	ATION				100	I. INSIDE CITY LIMITS?
ermit.		Md . 10a. STREET AND NUMBER	l t	Baltimore	-	Cato	nsville 1	Of, ZIP CODE			10g, CITIZE		YES 2 NO
n. ansit p	FRAL	601 Maide	n Cho	ice Lane				21228				USA	
hysicia urial-tr	FUN	11. MARITAL STATUS 1 Never Merried 2	Merried	12. WAS DECEDENT FORCES? 1	EVER IN U.S. A	RMED NO	13. WAS DE	CENDENT OF HISPA pecify Cuben, Mexico	NIC ORIG	IN? (Specify Yea Rican, etc.)			Americen Indien, lite, etc.
the hospital or attending physician detached for use as the burial-trai	ВУ	3 ₩ Widowed 4 □ Divo		IF YES, GIVE W	AR OR DATES		1 🗆 YE	S 2 NO Specifi	fy:	STELLEY.		Specify:	white
or atter	ETED	(Specify only	EDENT'S EDU y highest grade	CATION completed)	(0	ECEDENT'S Give kind of w	USUAL OCCUPAT	ION lost of working	16	b. KIND OF BUS	INESS/INDU	STRY	
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the hospit e detached	COMPL	17. FATHER'S NAME (First, M					41102	18. MOTHER'S NA		Middle, Maiden S			
· 5 5 6	띪	Michael Ca		1	T.,			Cecilia			-		
(f) as	٤	Margaret J		aras				and Number or Rural ., Baltin			1, State, Zip C 21234	ode)	
. Page 6 may be ral director, page :		20e. METHOD OF DISPOSITI	n 3 🗆 Rem	oval from State	20b. PLACE	AND DATE O	F DISPOSITION /	lame of	DA	TE 20c. LOC	CATION - CH		
tuneral director,		4 Donation 5 Other 21. SIGNATURE OF FUNERAL		CENSEE A	More	land 1	Memoria	l Park	ICH ITY	29 Bal	timor	e, Md	•
fune fune		· Opek	iek	1. Sho	mma	2~-	Gary	L. Kaufma	an Fu	neral	Home o	of El	
after by the mova		23. PART Enter the di	iseases, or	complications that	caused the d	eeth. Do n	ot enter the m	Main St.,	h es ca	Cridge,	Md.	2122	Approximete
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ompletely filk il, cremation, event, the		disesse or condition	→			pean	dia in	farction	7				Hour
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		1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.						
		1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY				3. TIME OF DEATH
		BERNARD HANDY					JÜLY 29	1995	18:22 P M
2, 3 should		4. SOCIAL SECURITY NUMBER 213-62-5707	1 M 2 - F	YRS. In the state of the state	1 YEAR # UND	ER 24 HRS. 7. D	ATE OF BIRTH Month, Day, Year,		THPLACE (State or Foreign
	OR	9a. FACILITY NAME (If not institution, give str 5100 DARIEN RD			LTIMOR			9c. COUNTY OF	PEATH
	ECT	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	1	10c. CITY_TOWN	OR LOCATION				Last mains are:
permit. Pages	AL DIR	Maryland 10. STREET AND NUMBER	N/A	Ba	Hime	ore			10d. INSIDE CITY LIMITS? 1 YES 2 NO
215-0020 attending physician. se as the burial-transit pe	FUNERA	5/00 Darien	Rd.		101. ZIP CO	206		U.	S A
	B	1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	E-NO	WAS DECENDENT If yes, specify Cut 1 YES 2 A	oen, Mexican, Pu	RIGIN? (Specify Yes arto Rican, atc.)	Bi	ACE — American Indian, ack, White, atc.
Se aft	ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working							
;, MAKYLAND 2- be retained by the hospital or ge 5 should be detached for e notified at once.	COMPLE	Elementary/Secondary (0-12)	College (1-4 or 5+)	Self e	mplo	ved	/	VIA	
	BE CO	Bernard Ca	SSEV HO	andy	Be Be	THER'S NAME (F	irst, Middle, Meiden e Mo	surdamo)	Brooks
	5	onstance	Handy	5100 Da	(Street and Numb	er or Rural Royte	Balta	n, State, Zip Code)	21206
e 6 may rector, pa		20e, METHOD OF DISPOSITION 1		CE AND DATE OF DISPOS	ITION (Name of	8/	3/95 LA	CATION - GITY OF	Town, State
SALT death. e funera al. exami		21. SIGNATURE OF FUNERAL SERVICE UCENSEE 22. NAME AND ADDRESS OF FACILITY JOSEPH L. RUSS FUNERAL HOME 22.2 W. North Ave Batta Md. 21716							
filled in I		23. PART I Enter the diseases, or co shock, or heart failure. L iMMEDIATE CAUSE (Finel disease or condition	at Dnly Dne ceuse on sech	ilna.		ying, such as	cerdiac or reapi	iratory arreat,	Approximate Interval Between Onset and Daeth
ed within ompletel al. crema		disease or condition resulting in death) a. Curhosis of the Civer DUE TO (OR AS A CONSEQUENCE OF):							
and and bur	ATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING							
ie physication	CERTIFICATIO	CAUSE (Disease or injury thet initiated events resulting in death) LAST							
D.S., P.O. The death certification of the Mental Hygie	SE	d							
ad the second	EDICAL	PART II. Other significent conditions contributing to death but not reaulting in the underlying ceuse given				given in Part	PERFORMED?		4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
TECUITES Seen sign of Heal shows	Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTA					. 1		1 SYES 2 NO
I. The law cate has b State Dept.	SICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:							
CIAN: ertific the Si	YS	1X YES 2 □ NO	I Inpatient 2 ER/Outpatier	nt 3 DOA 4 Nur	sing Home 🎇 F	Residence 8 🗆 (Other (Specify)		
NG PHYSIC fler this ce eath with t	ву РНҮ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?		DEŞCRIBE HOW I	NJURY OCCURED	
TTENDI TTOR: A after d	8	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — A building, etc. (Specify)	e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f.	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
Dien Dien	PLE	29e. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and manner as stated.							
THE HOSPITAL THE FUNERAL filed within 72	COMPLET	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(e) end manner as stated.							
THE HOSPIT THE FUNER. filed within 7	BE (29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICEN			CENSE NUMBER	NUMBER 29d. DATE SIGNE		ED (Month, Day, Year)	
D C S S S S S S S S S S S S S S S S S S	10 E	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				OCME	OCME JULY 30,1995		
	DONALO G WRIGHT MA 111 Ponn Street Ba								and 21201
_		31. DATE FILED (Month, Day, Year) AUG 0 2 1995	22, REGISTRAR'S SIGNATUR	Zally				1-	



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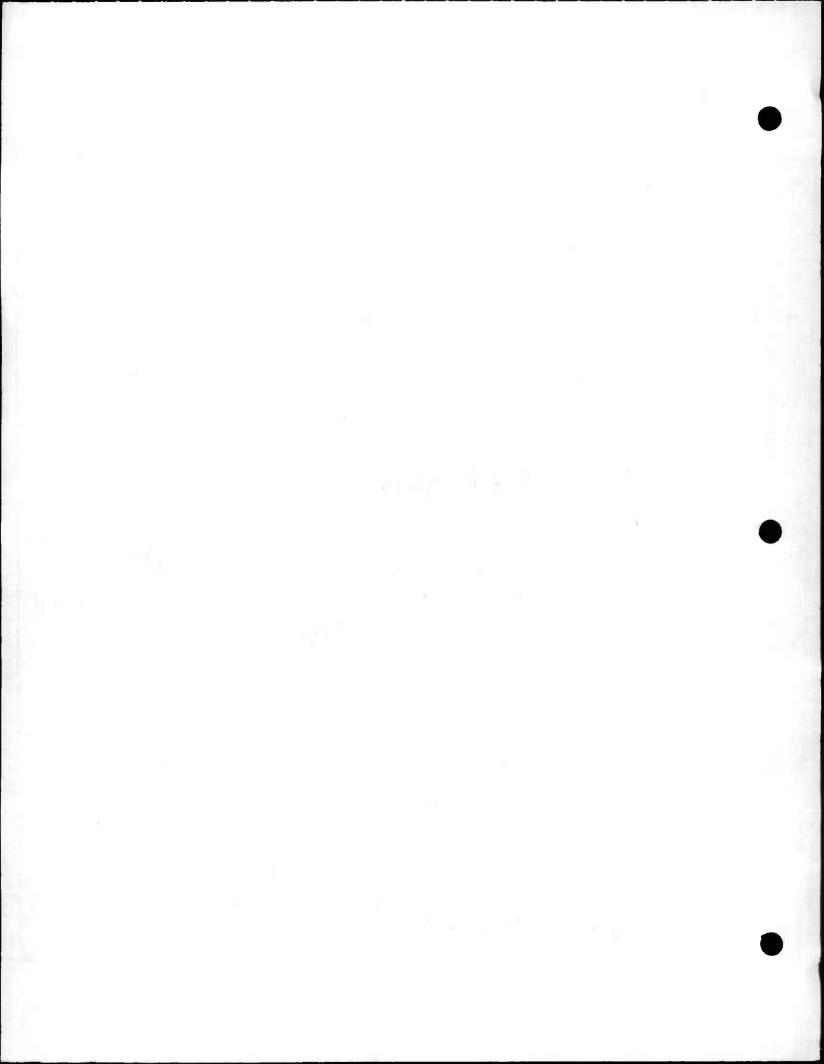
			1 - STATE REGISTRAR		MARYLAND /		ICATE			MENTAL	REG. NO.	_		
			1. DECEDENT'S NAME (First, Middle, Li	nat)						2. DATE (YEAR	3. TIME OF DEATH
			PAUL	RICHARD		HI	LL			JUL			995	03:02 M
			4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le	st birthday)	IF UNDER 1 Y		OER 24 HRS.	7. DATE C		T	8. BIRTHP	LACE (State or Foreign
	, l		215-74-0557	1 X M 2 🗆 F	39	YRS.	MONTHS D	AVS HOUR	S MIN.		26,	1955		vland
	should		9a. FACILITY NAME (If not institution, g.	ve street end number)			9b. CITY, TO	WN OR LOC	ATION OF DE				TY OF DE	
	2, 3	DIRECTOR	University H	ospital			i	Ba1	timor	e		Ral t	imor	e City
	-	딦	RESIDENCE OF DECEDENT 10e. STATE 10b. COL									Dar		
	ž	Ë				IVC. CIT							i i	10d. INSIDE CITY LIMITS?
	permit. Pages		Maryland Ca	rroll Cou	nty		Syke	svill						1 X YES 2 NO
	8 #	A	, and 7 or 12 or 1	D- 1 4 .				10f. ZIP C				10g. CITU	ZEN OF WI	HAT COUNTRY?
cian.	burial-transit	FUNERAL	7420 Village		L /	2452	40 1111		21784				S.A.	
)20 Jhysic	ourial		1 Never Married 2 X Merried	FORCES?	1 YES 2 X		If ye	s, specify C	uban, Mexica	n, Puerto R	(Specify Yealcen, etc.)	or No—	14. RACE Black,	- American Indian, White, etc.
215-0020 attending physician	as the t	B	3 Widowed 4 Divorced	IF YES, GIVE	MAR OR DATES		1 [YES 2 XI	NO Specify	y:		ł	Specify	White
215 attend	e as		15. DECEDENT'S		16e. Di	ECEDENT'S	USUAL OCCU	PATION		16b.	KIND OF BUS	SINESS/INDI	USTRY	MITTEE
212	for use	ᇤ	(Specify only highest g Elementary/Secondary (0-12)	College (1-4 or 5	HA:	Give kind of B. Do NOT u	work done durii se retired.)	ng most of wo	orking					
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AND 2	detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)					-	OTHER'S NA	ME (First, M	iddle, Maiden		ATGE	
£ 7	2 %	ш	Paul Roger	Hill					Jean :	Shir1	ey Hi	nson		
MAR	5 should notified	8	19a, INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (S						Code)	
be ret	ω <u>Ε</u>	2	Mr. Paul Roger	Hill (Fath	1		Box 2							
may b	page :		20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 F		20b. PLACE	ANDDATE	OF DISPOSITIO			DATE		CATION - C		n, Stata
0	must		4 Donation 5 Other (Specify)	amover from State	Carr	oll (cremat:	ion Se	erv. 8	8/1/9	5 Har	npste	ad.	MD
ALLIMORE, death. Page 6 may be funeral director, page			21. SIGNATURE OF FUNERAL SERVICE	LICENSEE			22. NAI	E AND ADD	RESS OF FA	CILITY				
BALTIMORE, er death. Page 6 may be	e funeral dir I. examiner		► Voring.	X.An	dat						ME (P			•
after after			23. PART I. Enter the diseases,	or complications th	y caused the de	anth Do		ykes	ville.	, MD	21/84	(410)-79	5-1400
hours			anock, or neert rend	re. List only one car	use on each line	B	not entar the	moda or	ayıng, suci	h aa cerdi	ec or reapi	ratory arre	est,	Approximete Interval Between
T.	Pe o		IMMEDIATE CAUSE (Fine)											Onsat and Death
within	completely fille fal, cremation, event, the		resulting in death)		STOLIC OR AS A CONSE	OUENOE O	D.							SECONDS
	2 - 2	_				OUENCE U	r).							
cxecuted	siclan and control to buria	RTIFICATION	Sequentially list conditions,		POXEMIA (OR AS A CONSE	OUENCE O	F):							MONTHS
BO)		¥	cause. Enter UNDERLYING											t-TDDIG
tiffica	other	Ē.	CAUSE (Disease or injury that initiated events	DUE TO	(OR AS A CONSE	OUENCE O	MORRHA F):	GE						WEEKS
P.0	BE F	E	reaulting in death) LAST	d.										
DS, P.O. BC the death certificate	ned by the attentith and Mental any Injury, o	8	DART II Other electrices and											
DRDS, that the de	and h	MEDICAL	PART II. Other aignificent condit	ione contributing to	deeth but not i	reeuiting	in the under	lying caus	e given in	Part I.	24a. WAS AN A PERFOR			VERE AUTOPSY FINDINGS WAILABLE PRIOR TO
S E	alth salth	ă								_	1 YES 27	NO D		COMPLETION OF CAUSE OF DEATH?
REC.	been sign of, of Heal 3 shows												1	YES 27 NO
3¥ L	Dept.	ä	DID TOBACCO USE CON						CERTAIN	4 D				
— F	State (HYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	CE OF DEA	OTHER:	one)						
CIAN	the S	YS	1 TYES 2 NO		ER/Outpetlant 3	_	4 - Nursing	Home 5 🗆	Rasidence	6 🗆 Other	(Specify)			
P SE	with ked,	표	27. MANNER OF DEATH 1 ☑ Natural 5 ☐ Pending	28a. DATE OF (Month, E		28b. TIM	E OF 280	WORK?		28d. DESC	RIBE HOW IN	NJURY OCC	URED	
Z S	After this death with s marked	À	2 Accident Investigation					YES 2	□ NO					
VISION OF VI	after d		3 Suicide 6 Could not 4 Homicide detarmined	ou building.	OF INJURY — At he etc. (Specify)	ome, farm,	street, factory,	offica		28f. LOCA City or	TION (Street a. Town, State)	nd Number o	or Rural Ro	ute Number,
OR ATTENDIN	DIRECTOR: hours after item 28 is	品用									- 11			
_ 4	그 이 누	COMPLI		YSICIAN: To the best of										
THE HOSPITAL	FUNERAL (Within 72 h TTANT: If II	ő	2 MEDICAL EXAM	INER: On the beels of e	xamination and/or	Investigatio	n, in my opini	on, death oc	cured at the	time, data a	nd place, and	d due to the	cause(a)	and manner ea stated.
五	HE FL	шШ	296. SIGNATURE AND TITLE OF CENT	FIER				29c. L	ICENSE NUM	IBER		29d. DATE	SIGNED (Wonth, Day, Year)
2	TO THE FUNERA De filed within 7 IMPORTANT: I		1/004	gn				m	2043	563	0	▶ 7,	/31/9	95
	,	٤	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAU				10. 14						
(ا و		KOBEM.	KON	22. S	GREEN	E ST.	BALT	EMORE,	, MD	#21201	L		
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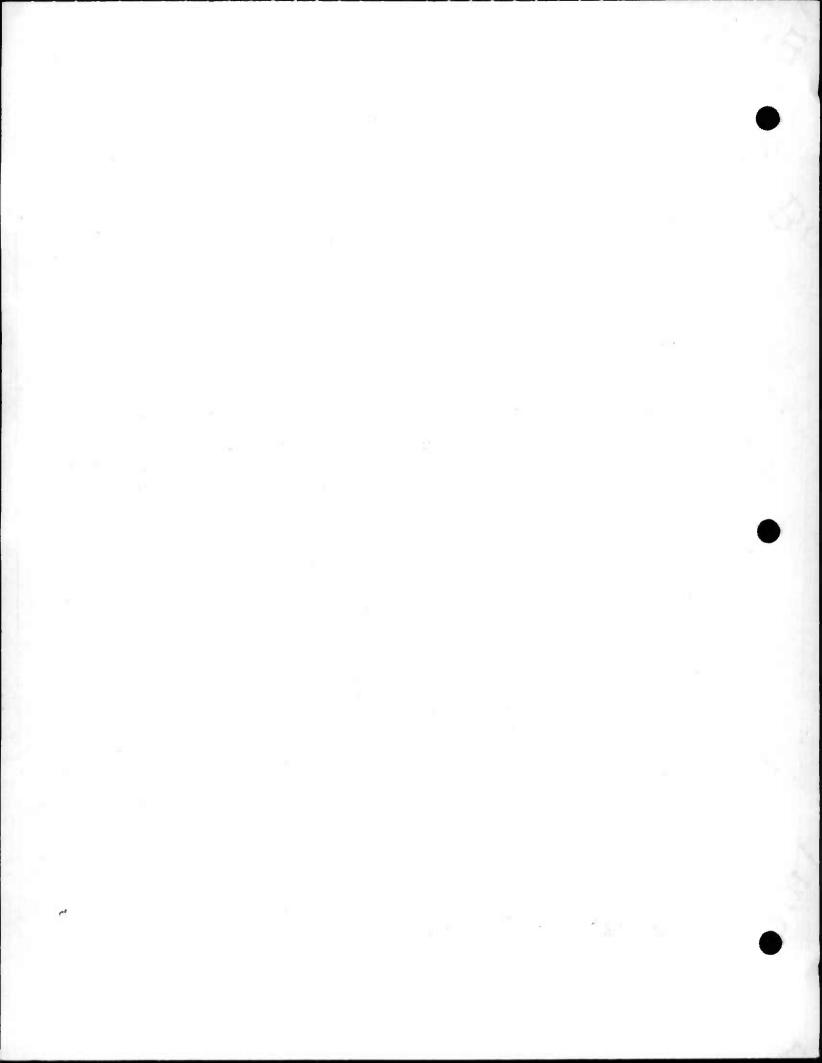
		1 - STATE REGISTRAR	STATE OF MARYL			HEALTH AND F DEATH	MENTAL HYGIEN REG. NO				
		1. DECEDENT'S NAME (First, Middle, Lest) LUTHER	LEE		JOHNSON		2. DATE OF DEATH DATE OF DATE OF DEATH DATE OF DATE OF DEATH DATE OF DAT	1995			
Þ		4. SOCIAL SECURITY NUMBER 248-74-8816	5. SEX 6. AGE	(In yrs. last birthday) 50 YRS.	MONTHS DAYS		7. DATE OF BIRTH DEC 22 19	44	IRTHPLACE (State or Foreign ountry) S.C.		
2, 3 should	RECTOR	90. FACILITY NAME (If not institution, give str UNIVERSITY HOSPI				N OR LOCATION OF D	EATH	9c. COUNTY			
Pages 1. 2		RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY				TOWN OR LOCATION 16d. INSIDE					
permit. P	AL DIR	10e. STREET AND NUMBER			BALTIMO	RE 101. ZIP CODE		10g. CITIZEN	1 X YES 2 NO		
cian. -transit	FUNERAL	135 PA	LORMO AVE	MIIS ADMED	12 42 48 5	Α.					
	TO BE COMPLETED BY FI	1 Never Married 25 Merried 3 Wildowed 4 Divorced	FORCES? 1 2 YES 11-8-67 thru	2 NO	If yes, specify Cuben Mexican Puedo Pican etc.)						
he hospital or attending detached for use as the once.		15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)		16a. DECEDENT'S (Give kind of life. Do NOT u MATL (work done during se retired.)	during most of working					
be det		17. FATHER'S NAME (First, Middle, Lest) RUBIN JOHNSON 16. MOTHER'S NAME (First, Middle, Meiden Surname) GERETHA L. BROWN									
s retain 5 sho		19a. INFORMANT'S NAME (Type/Print) MABEL JOHNSOI	1		3 ADDRESS (Street		Route Number, City or Tow BALTO, MD 2)		
e 6 m rector, must		20e. METHOD OF DISPOSITION 1 Description 1 Description 2 Description 3 Description 3 Description 4 Description 5 D	val from State	PLACE AND DATE RESERVE COMMERCE OF CONTROL O				CATION — CHY O DWING M	r Town, State ILLS MD		
r death ne fune al.		21. SIGNATURE OF FUNERAL SERVICE LICE	11 2	wpsm	1	AND ADDRESS OF FA	.H. 4300 W	ABASH			
ficate be executed within 24 hours physician and completely filled in the prior to bunial, cremation, or rener traumatic event, the median	RTIFICATION	23. PART I. Enter the diseases, or complications that caused the beath. Do not anter the mode of dying, such as cardiec or respiratory armst. IMMEDIATE CAUSE (Final disease or condition resulting in death) SEPTIC SHOCK (VIBRIO VULNIFCUS—BLOOD CULTURE) DUE TO (OR AS A CONSEQUENCE OF): a. NECROTISING—FASCITIS DEFT DEC. DUE TO (OR AS A CONSEQUENCE OF): RENAL FAILURE C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
t the death by the atten nd Mental H injury, o	CAL CER	PART II. Other significent conditions	contributing to deeth b	ut not resulting	in the underly	13.		AUTOPSY	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
w requires been signi it. of Healt	AN: MEDI	DID TOBACCO USE CONTR	BUTE TO CAUSE C	F DEATH YE	S NO	W UNCERTAIL	1 X YES 2	□ NO	COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO		
SICIAN: The law certificate has to the State Dept 1, or item 23	SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA	TH (Check only on OTHER:		B ☐ Other (Specify)				
The with	у РНУ	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	7/15/95	26b. TIM	E OF 28c, II	NJURY AT VORK?	28d. DESCRIBE HOW I				
) 5 4 5	тер ву	2 X Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Spec CURTIS B.	cify)		lice	NO FISHING ACCIDENT 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) BAY				
AL OR	COMPLET		AN: To the best of my knowl					nner ee atated.	se(e) end manner ee stated.		
TO THE HOSPIT TO THE FUNER De filed within ? IMPORTANT: I	TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	^			29c. LICENSE NUI D45106	MBER		NED (Month, Day, Year)		
			750N	22		ENE ST. BA	ALTIMORE, MI	21201			
		AUG 0 2 1995	32 BEGISTRAR'S CON	2012							



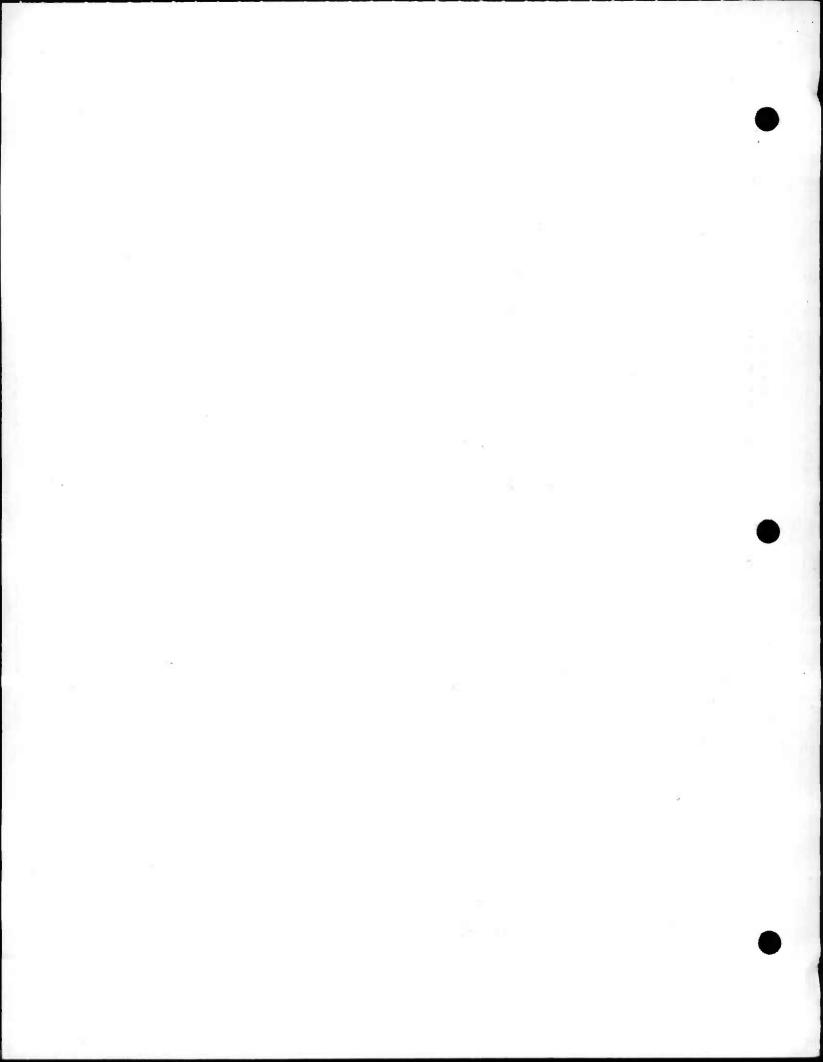
MARYLAND 21215-0020	h Pane & may be retained by the honeing or estanding the
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BALTIMORE ,	death
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		REGISTRAR	ATE OF MARYLA		TMENT OF I		MENTA	L HYGIEN REG. NO.	E			
		1. DECEDENT'S NAME (First, Middle, Last) JOAN	Ann	101	HNSON		MONT	H DA	100	EAR .	TIME OF DEATH	
		4. SOCIAL SECURITY NUMBER 5. SE		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	LY 30			21:41P	М
should		212-52-9368 1 9s. FACILITY NAME (If not institution, give street and	M 2 💢 F 47	YRS.	MONTHS DAYS	OR LOCATION OF E	Aug	n, Day, Year)	947	country) Mary	land	
2,	ECTOR	550 E. FORT AVE			BALTI		Cit	У	9c. COUNT	Non		
Pages 1,	EC	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY			_
permit. Pa	L DIR	Maryland None	2			.City,M	ld.				LIMITS? XYES 2 NO	
12	ERAL	550 E.Foi	rt Ave.		10	or. ZIP CODE 212	30				tates	
215-0020 attending physician. se as the burial-transit	FUNER	1 Never Married 2 N Married FO	AS DECEDENT EVER IN DRCES? 1 YES	2 NO	If yes, sp	CENDENT OF HISPA	ANIC ORIGI	N? (Specify Yes Rican, stc.)		Black, W	American Indian	_
	ED BY	3 Wildowed 4 Divorced 15. DECEDENT'S EDUCATION	YES, GIVE WAR OR DAT			S 2 NO Spec					White	
2 2 2	ᇤ	(Specify only highest grade complete	ge (1-4 or 5 +)		USUAL OCCUPATI work done during me retired.)		164	o. KIND OF BUS	HNESS/INDUS	TRY		
AND the hospital detached for	COMPL	10th.Grade No	one	Homer	naker				Home			_
क दित्र	ш	Joseph	n Fuch	nslugei		Anna			_{Sumame)} Ionaha	a n		
MARYL. retained by the 5 should be contified at continuous	10 B	19a. INFORMANT'S NAME (Type/Print) Mr.Lloyd A.Johnso	22			and Number or Rura				ide)		-
. 2 e		20s. METHOD OF DISPOSITION	20h 5		E.FOTT	Ave.B	alto		1230	y or Town	State	_
MOR ge 6 ma irector, p		1 Burisi 2 Cremation 3 Removal fro	m State cemei	tery, crematory or o	ther place!	netery,					Stata	
BALTIMOR er death. Page 6 ma the funeral director, p vai.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE	11	7		ND ADDRESS OF F			to.Mo	11.7.	230	-
BA rs after de n by the fu removal.		Nanul U.	1 Dy lor		McCu1	.1y Fun	eral	Home	,130	E.F	ort Ave	
5 - 9		23. PART i. Enter the diseesea, or complice ehock, or heart failure. Liet on	cetione that caused ily one ceuse on eed	the death. Do r ch line.	opt enter the mo	ode of dying, su	ch aa cer	diac or reepi	retory arree	t,	Approximate interval Between	
the tion		iMMEDIATE CAUSE (Final disease or condition reaulting in death)	Smoke	inhal	ation						Onset end Deati	19
executed within and completely o burial, cremar			DUE TO (OR AS A	CONSEQUENCE OF	7):							_
OX 68 e be execut sician and c nior to buris traumatic	CATION	Sequentially list conditions, if eny, leading to immediate	DUE TO (OR AS A C	CONSEQUENCE OF	F):							_
ifficate to physic ene prior prior tra	FICA	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A C	CONSEQUENCE OF	7):							_
the death certificate the attending physical Mental Hygiene principle.	CERTIFI	resulting in death) LAST										
TRDS, F nat the death I by the atter and Mental IV Injury, o	CALC	PART II. Other significent conditions conti	ributing to deeth but	t not resulting i	n the underlyin	g ceuse given ir	n Part I.	24a. WAS AN			RE AUTOPSY FINDINGS JLABLE PRIOR TO	-
7 = 8 = 51	MEDIC	-						1 TYES 2	15.50	COI	MPLETION OF CAUSE DEATH?	
w requi		DID TOBACCO USE CONTRIBUT	E TO CAUSE OF	DEATH YE	S II NO I	UNCERTA	IN \square			1 [YES 2 NO	
N: The law in the law	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			H (Check only one)							
SICIAN: The Certificate the State	HYSI	1 YES 2 NO 1 In	patient 2 ER/Outpet	lent 3 DOA		Ne 5X Residence	_				· · · · · · · · · · · · · · · · · · ·	
DING PHYS After this of death with	BY PI	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) 7-30-61	INJ	URY WO	YES 2 NO		POOD (1 tox	ise.	Fire	
OR ATTENDING PHYSICIAN: The law requires DIRECTOR: After this certificate has been sign hours after death with the State Dept. of Healt III an 28 Is marked, or Item 23 shows			8s. PLACE OF INJURY - building, atc. (Specify	7)	treet, factory, offic	:0	City	ATION (Street a or Town, State)	nd Number or	Rural Route	Number,	_
	Ē	29s. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To		MC death occurre	d at the time date	and place, and du	550		OF 170	R 1	Sulpmore	
THE HOSPITAL THE FUNERAL filed within 72 I	COMPLET	one) 2 MEDICAL EXAMINER: On the	ne beals of examination	and/or investigatio	n, in my opinion, o	leath occured at the	e lime, data	and place, and	dus to the c	suse(s) sni	f menner as stated.	
THE HOSPI THE FUNER filed within	BE	296. SIGNATURE AND TITLE OF CERTIFIER	0461			29c. LICENSE NU					nth, Day, Year)	_
223	2	30. NAME AND ADDRESS OF PERSON WHO COMP	LETED CAUSE OF DEAT	H (ITEM 27) (Type,	Print)	OCM	E		JU	JLY	31,1995	_
5		Vovid R F	enter	111 P	enn Sti	ceet, B	alti	more,	Mary	ylan	d 21201	
			2. REGISTRAR'S SIGNAT									
,	النا	AUG 0 2 1993	The state of the s								DHMH-16 Rev I/	/R

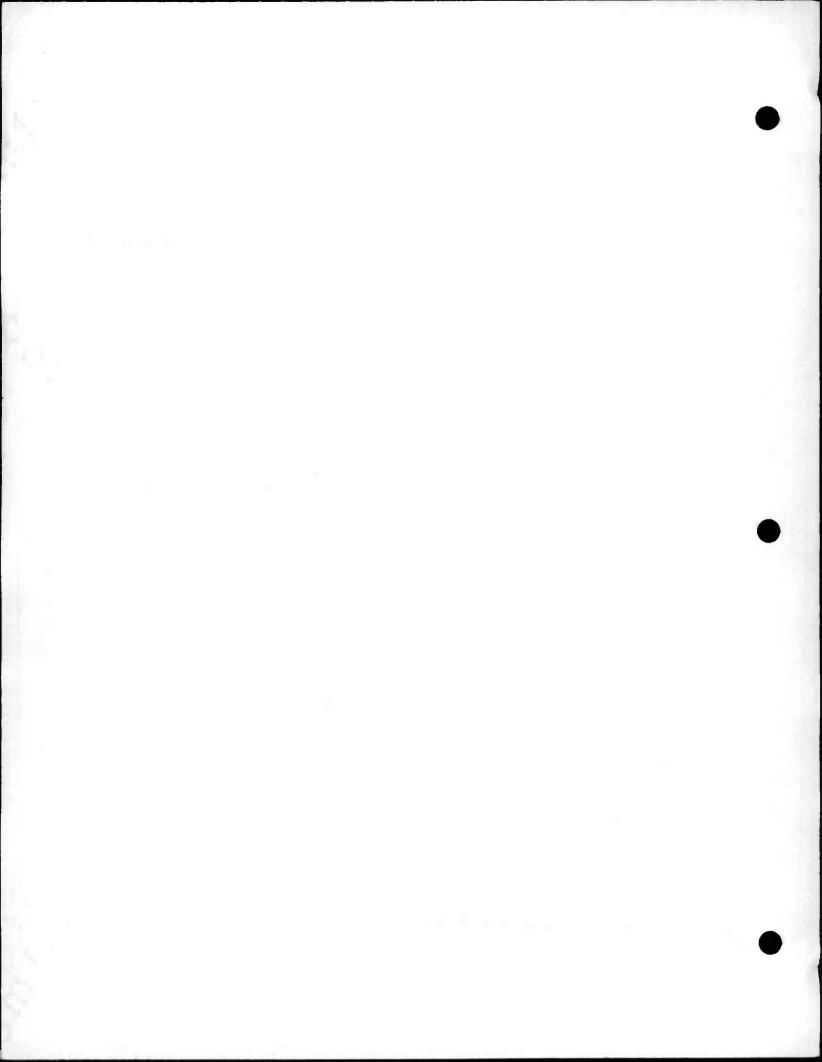
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		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMENT OF H	IEALTH AND N	MENTAL HYGIEN		
		1. DECEDENT'S NAME (First, Middle, Last)	L T	ONE			2. DATE OF DEATH		3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS, HOURS MIN,	7. DATE OF BIRTH	A. BIRTHP	LACE (State or Foreign
should		212-05-4157 9e. FACILITY NAME (If not institution, give str	1 № M 2 ☐ F 7"	7 YRS.		OR LOCATION OF DE	Oct. 10,1		ginia
2, 3 sh	O.B.	Church Hospital			Balti		AIH	9c. COUNTY OF DEA	ATN
-	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAL				10d. INSIDE CITY
permit. Pages		Md. Balti	more		ındalk				LIMITS?
	RAL	10a, STREET AND NUMBER		-	101	. ZIP CODE		10g. CITIZEN OF WI	
020 physician. burial-trans	FUNERAL	3 Eastship Road	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	21222 ENDENT OF NISPANI	IC ORIGIN? (Specify Yes	U.S.A	- Amarican Indian,
21215-0020 al or attending physician. for use as the bunal-transit	BY F	1 Never Merried 2 Merried 3 Widowed 4 X Divorced	FORCES? 1 YES		II yes, sp	ecify Cuben, Mexican 2 NO Specify:	, Puerto Rican, etc.)		White, etc.
1215-0 ir attending use as the		15. DECEDENT'S EDUC	W.W.II U.	16e. DECEDENT'S	USUAL OCCUPATION	ON	16b. KIND OF BU	Whit	e
21: Ifor us	COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT u	100 CA.	st of working			
the hospital or detached for u	PMP	17. FATHER'S NAME (First, Middle, Last)	1	Offic	:e	18 MOTNED'S NAM	B.G.	& E. Co.	•
YL/	BEC	Robert Crawley	Jones			Marie		Surname)	
MARYLAND 2- retained by the hospital o 5 should be detached for notified at once.	2	190. INFORMANT'S NAME (Type/Print)					oute Number, City or Tow		
		Robert Jones 200 METHOD OF DISPOSITION	206.		DUNMU OF DISPOSITION (No			CATION - City or Town	
0 6 7		1 Duriel 2 X Cremetion 3 Remo	val from State ceme	etery cremetory or o	ther place) Lke Cre	matory	8-1-95 B	Beltsvill	Le.Md.
BALTIMORE, after death. Page 6 may be by the funeral director, page moval.		21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	_	Brad	DADDRESS OF FAC	ton Fune	ral Home	$^{2}1222$
BA rs after de n by the fu removal.		J. M. Farrage	erkens					Rd.,Balt	co.,Md.
hours or rel		23. PART i. Enter the diseases, or or shock, or heart failure. L IMMEDIATE CAUSE (Fine)	omplications that ceused list only one ceuse on ea	the death. Do i ich line.	not enter the mo	de of dying, auch	aa cerdlac or respi	iretory arrest,	Approximate Interval Between
in 24 atlon.			PREUN	102/1	4				Onset and Death
cecuted within and completely to burial, crematic			DUE TO (OR AS A	CONSEQUENCE O	F):				
and and bur matic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate	OUE TO (OR AS A	CONSEQUENCE O	F):				
BOX ficate be physician he prior to	ICA	CAUSE (Disease or injury	DUE TO (OR AS A	COMPEQUENCE					
b, P.O. E death certifica attending phymal Hygiene ry, or other	F	that initiated events reaulting in deeth) LAST	50E 10 (ON AS A	CONSEQUENCE OF	r):				
S, he at Ment		PART II. Other significent conditions	contributing to deeth by	ut not resulting	in the underlying	ceuse given in F	Part I. 24s. WAS AN	AUTOPSV 245 A	VERE AUTOPSY FINDINGS
₩ # # # M	JICAL	CHRONIC	LUNG	DISE,	A56,	MYELO	MAY VES	RMED?	WAILABLE PRIOR TO COMPLETION OF CAUSE
RECO requires the peen signed of Health	MEDIC	CORONAI	ZY HEAL	270	15EA.	35		· ·	F DEATH?
L law	AN:	DID TOBACCO USE CONTR		F DEATH YE		UNCERTAIN			
VITAL RECO JAN: The law requires the state has been signed he State Dept. of Health or Item 23 shows an	PHYSICIAN:	EXAMINER?	HOSPITAL: 1 層 Inpatient 2 □ ER/Outpe		OTHER:	e 5 🗆 Residence 8	Other (Specify)		
. 0 55	F	27. MANNER OF DEATN 1 № Natural 5 Pending	26s. OATE OF INJURY (Month, Day, Year)	28b. TIM INJ	E OF 28c. INJ	URY AT	28d. DESCRIBE NOW I	NJURY OCCURED	
ION OF NDING PHYSI T After this or r death with Is marked,	B	2 Accident Investigation	28e. PLACE OF INJURY	- At home, farm,		ES 2 NO	281. LOCATION (Street of	and Number or Rural Rou	de Number
2 # 19 H 2	ETED	4 Nomicide 8 Could not be determined	building, etc. (Speci	fy)	, , , ,		City or Town, State)	mo Hamps or Harat Hoc	na reamba,
DIV TAL OR A AL OIREC 72 hours ## item	AP.		IAN: To the best of my knowle						14.
HOSPITAL FUNERAL Within 72 TANT: #	COMPL	2 MEDICAL EXAMINER	On the beele of examination	end/or investigation	n, in my opinion, d			d due to the ceuse(e) e	nd menner ee stated.
물 물 을 등	BE	296. SIGNATURE AND TITLE OF CERTIFIER	emi n	200-		D/73		29d. DATE SIGNED (A	7.00
P P 3 W	5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TN (ITEM 27) (Type	Print)				31,1975
		31. DATE FILED (Month, Day, Year)	MI, M-6/2		new l	+OSPITA	AL, BA.	the wo	-1251
		AUG 0 2 1995 July	32. REGISTRAR'S SIGNA	II CHE					
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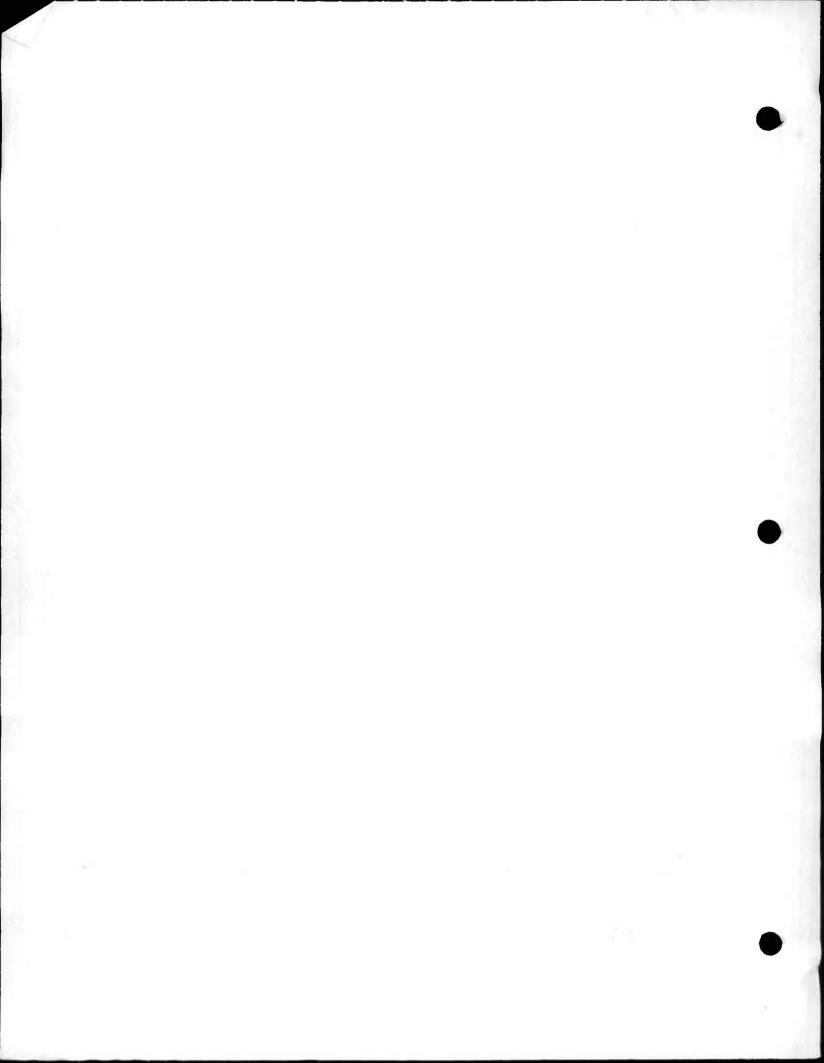


		FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	RTMENT OF I	HEALTH AND	MENTAL HYGIEN			
		1. DECEOENT'S NAME (First, Middle, Last CAROLYN SUE	JONES				2. DATE OF DEATH MONTH JULY 29,	MY 0.95	3. TIME OF DEATH 8:33 P M	
		4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIRTH		BIRTHPLACE (State or Foreign	
모		404-54-2033	1 🗆 M 2 💢 F	54 YRS.	MONTHS DAYS	HOURS MIN.	JULY 23,	1941	Country) Kentucky	
3 should	~	9a. FACILITY NAME (If not institution, give				OR LOCATION OF DI	EATH	9c. COUNTY	Y OF DEATH	
1, 2, 3	DIRECTOR	THE JOHNS HOPKIN	IS HOSPITAL		BALTIM	ORE CITY			N/A	
Pages	BE	Md. Pr			T, TOWN OR LOCA				10d. INSIDE CITY LIMITS?	
permit. Pages		10a. STREET AND NUMBER	rince Georges		Temple H	111S		Tan CITITE	1 YES 2 NO	
sit	FUNERAL	4710 Sharon Roa	ad		100	20748		10g. CITIZEI	USA	
020 physician. burial-transit	N N	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	N U.S. ARMED	13. WAS DEC	CENCENT OF HISPAN	NIC ORIGIN? (Specify Ven, Puerto Rican, etc.)	10 or No- 14	Black, White, etc.	
15-00; ending ph as the bu	ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D			S 2 X NO Specify		Specify:		
21215-0020 If or attending physician for use as the burial-tra	03	15. DECEDENT'S ED (Specify only highest grad	DUCATION de completed		USUAL OCCUPATI		16b. KIND OF BU	JSINESS/INOUS	white	
21 al or for u	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	work done during mose retired.)	ost of working				
YLAND 2 by the hospital be detached to at once.	JMP	12 17. FATHER'S NAME (First, Middle, Last)	4	Homen	naker		Own H			
YLA by the be de		John Burton May	hew				ME (First, Middle, Malder Llie Presto	,		
MARYLAND retained by the hospit 5 should be detached notified at once.	TO BE	19a. INFORMANT'S NAME (Type/Print)	11011	19b. MAILING	AOORESS (Street)		Route Number, City or Tox		ode)	
	۴	Charles Jones					e Hills, N	Md. 20	0748	
TORE, e 6 may be rector, page must be		20a. METHOD OF DISPOSITION 1 Department D	moval from State 20b	b. PLACE AND DATE (metery, cremetory or o lighland	OF DISPOSITION (No other place)	eme of			y or Town, State	
Page al direc		21. SIGNATURE OF PUNERAL SERVICE L	ICENSEE / >	iigniand		L Park		ttordsv	/ille, Ky.	
BALTIMORE, MARYLAND after death. Page 6 may be retained by the hospit by the funeral director, page 5 should be detached moral.		· Lary	L. Loufn	reny				Home o	of Elk., Inc. 21227	
e in the		23. PART I. Enter the diseases, or ahock, or heart bilium	r complications that caused b. List only one cause on a	d the death. Do r	not enter the mo	ode of dying, auc	h as cerdiec or reep	Iratory erreef	Approximate Interval Between	
Pe on all		IMMEDIATE CAUSE (Finel disease or condition	Metastatic	Breact	1000	•			Onset and Death	
ted within 24 completely fille ial, cremation, event, the	H	reaulting in death)		A CONSEQUENCE OF					Ing. Tono.	
	×	Sequentielly liet conditions,	· Preumonta						Ink	
2 00 0	CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	diate Due to (or as a consequence of):							
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다 부 음을 위	ERT	resulting in death) LAST	d							
RECORDS, Frequires that the death een signed by the attent of Health and Mental shows any injury, or		PART II. Other significent condition	ona contributing to deeth b	out not resulting	In the underlyin	g ceuse given in	Part I. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS	
ORC that the ned by the tith and any in	SICAL						PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
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F VIT, rSICIAN: Th s certificate th the State d, or iten	PHYS	27. MANNER OF DEATH	1 Inpatient 2 ER/Outp 28a. DATE OF INJURY	28b. TIM	E OF 28c. INJ	IURY AT	8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUF	RED	
NG PHYS fler this ceath with marked,	ВУ Р	1 Naturel 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ		YES 2 NO				
TISIC NTTENDI CTOR: A after d	哥	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spec	— At home, farm, a	etreet, factory, offic		28f. LOCATION (Street City or Town, State	and Number or i	Rural Route Number,	
DIV TAL OR A TAL DIREC 72 hours 11 item	<u>P</u>	29a. CERTIFIER (Check only	SICIAN: To the best of my know	riedge, death occum	ed at the time, date	and place, and due	to the cause(a) and ma	nner as stated.		
HOSPITAL FUNERAL WITHIN 72	COMPL	2 MEDICAL EXAMIN	NER: On the beels of examination	n end/or investigatio	on, in my opinion, d	leath occured at the	time, date and place, ar	nd due to the co	ause(e) end manner as stated.	
물 물을 등	BE (SSO SGNATURE AND TITLE OF CERTIFIE	75/			29c. LICENSE NUM	IBER 152	29d. DATE SI	IGNED (Month, Dey, Year)	
₽ ₽ 3 M	2	30. NAME AND ADDRESS OF PERSON W		АТН (ITEM 27) (Туре,	, Print)	LUT	6 103	10 1 G	7/29/95	
			ETT, JR		s Harkins	Hospital	600 N.	Molte	St, Bult. MI)	
		31. DATE FILEO (Month, Dey, Year) AUG 0 2 1995	-32. FGISTRAR'S CH	APSE .					21287	



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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after de-	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fu
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	1. DECEDENT'S NAME (First	t. Middle. Lasti			CERTI	ICATE	OF				REG. NO.	_		
	CHARLES	Henry	KITZMAN						MONTH DAY YEAR				8:05 A.	
	4. SOCIAL SECURITY NUMBER 220: 18 28		5. SEX 1 M 2 D F	6. AGE (In y	YRS.		DAYS	IF UNDER	MIN.	(Month, Day, Year)				LACE (State or Foreig
Œ.	90. FACILITY NAME (If not it	A D Q 16						ON OF DEA					ATH	
DIRECTOR	RESIDENCE OF DEC	10b. COUNT		Mospice Towson							COL	TITT		
1	Md		Itimor	remor Perry Hall									10d. INSIDE CITY LIMITS? 1 YES 2 NO	
BY FUNERAL	106. STREET AND NUMBER 107. ZIP CODE 21236								EN OF W	HAT COUNTRY?				
	11. MARITAL STATUS 1 Never Merried 2 Divo	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ✓ YES 2 ☐ NO If YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC It yes, specify Cuben, Mexican, 1 ☐ YES 2 ☑ NO Specify:					NIC ORIGIN? (Specify Yea or No— 14. RACE — An Black, White Specify:							
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COMPLE	Elementary/Secondary (I	0-12)	College (1-4 or 5	·)	_	ERK				Sec	ciaL S	Secu	RITY	
ш	17. FATHER'S NAME (First, M	liddle, Last)	KITZM	AN						E (First, Middl JSTA		Sumame)	2	
TO B	190, INFORMANT'S NAME	party.			19b. MAILIN	G ADDRESS (S	Street an						Code)	
	Charles Gummer 9511 Oak Branch Way Balto Md. 21236 20s. METHOD OF DISPOSITION 1 Burlet 2 A Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION [Name of Campelogy of other place] Campelogy of other place]													
	4 Donetion 5 Other	(Specify)			ry, crematory or			mete	ery	1/27/95		uto	. Mc	1
	21. SIGN UVINE OF FUNERA	دلا	Ly.	ela	•	EVA	300 2N3	CHA HA	RFCR	of M	EMO	10.M		1234
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF):													
TIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events reauiting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):													
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C	if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or Inju- that initiated events	diate ING iry	eDUE TO	(OR AS A CO	ONSEQUENCE (DF):	rlying	cause g	liven in P		I. WAS AN PERFORM	AED?		AWAILABLE PRIOR TO
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1 YES 2 NO

27. MANNER OF OEATN

1 Natural

2 Accident

3 Suicide

funeral director, page 5 should be detached for use as the bunial-transit permit. hours after death. Page 6 may be retained by the hospital or attending physician. and completely filled in by the bunal, cremation, or removal. prior to the attending physician Mental Hygiene prior to requires that the death certificate be signed by the been of h s certificate has be th the State Dept. AMP. The L OR ATTENDING PHYSICIAN: TR L DIRECTOR; After this certificate ; hours after death with the State

Pages 1, 2, 3 should

ITEMS: 29c,29d, PER MEDICAL FACILITY FILM G-726 8/1/95 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3 TIME OF DEATH alphon 12:50 TIL D M 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday, 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAVE HOURS 1 M 2 SYF 172-01-0384 83 Nov. Hungary 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR Sinai Hospital Baltimore N/A 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/A Baltimore 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 7202 Valley Country Court Apt T-1 21208 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 25 THO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Maxican, Puerto Rican, atc.) 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 25 ANO 1 Never Merried 2 K Merried 1 YES 2 NO Specify: BY Specify. 3 Widowed 4 Divorced White 16a. OECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerk Los Angeles City Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Albert Schlesinger BE Jolan Kohn 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Mr. Ralston Kossis 7202 Valley Country Ct, Apt T-1, Baltimore, MD 21208 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Slate Nemoval from State Burial 2 Cremation Beth Israel 4 Donation 5 D Other 7/31/95 Los Angeles, CA 21. SIGNATURE OF PURE 22. NAME AND ADDRESS OF FACILITY Sol Levinson & Bros 6010 Reisterstown Rd, Baltimore, MD 21215 23. MRT I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximete List only one ceuse on each line. ahock, or heart IMMEDIATE CAUSE (Fine) Onset end Death diseese or condition_ Sessie hours resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in deeth) LAST PART ii. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 - YES 2 NO

1 TYES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN TO 25. WAS CASE REFERRED TO MEDICAL

26. PLACE OF DEATN (Check only one) OTHER: npatient 2 - ER/Outpatient 3 - DOA

INJURY

4 Nursing Home 5 Realdence 8 Other (Specify) 28b. TIME OF 28c. INJURY AT WORK?

28d. DESCRIBE NOW INJURY OCCUREO 1 YES 2 NO

Q766

▶ 7/29/95

28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 8 Could not be determined 4 Homicide 29a, CERTIFIER

28a. DATE OF INJURY

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. 2 MEDICAL EXAMINER: On

investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER SS 29b, SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)

Resdu 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Sivai

31. DATE FILEO (Month, Day.

Seven

5 Pending Investigation

Baltimore

Pages 1, 2, 3 permit. the funeral director, page 5 should be detached for use as the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 notified at pe must examiner or removal. medical attending physician and completely filled in by ntal Hygiene prior to bunal, cremation, or remo the event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 traumatic 0 signed by the atten Health and Mental F shows any to has b Dept. OR ATTENDING PHYSICIAN: The law 23 certificate f. 6 After this ce leath with t marked, After 1 death DIRECTOR: A hours after d item 28 is 60 TO THE HOSPITAL OF THE FUNERAL DE FIRED WITHIN 72 HOME IMPORTANT: If Its

ITEM: 23 PART I, PER MEO FILM G-727 9/13/95 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH **BRENDA** 1995 WILLIAMS KNIGHT JULY 30 02:14 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH
(Month, Day, Year)
July 12,1961 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 K F 336-60-1438 34 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR HOLY CROSS HOSPITAL MONTGOMERY n/a RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY TI. COOK CHICAGO 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5414 W. FULTON 60644 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 TO 1F YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Maxican, Puarto Rican, etc.) 14. RACE — American Indian, Black, While, atc. 1 Never Married 2 Married 1 TES 2 NO ВY Specify: Specify: 3 Widowed 4 X Divorced BLACK 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) SOCIAL WORKER CHICAGO CITY SCHOOLS 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) ROBERT WILLIAMS LORENE JOHNSON BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ROBERT WILLIAMS 5414 W. FULTON CHICAGO, IL. 60644 20s. METHOD OF DISPOSITION
12 Burlal 2 Cremation 3 Rem 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, Stata DATE BURR OAK CEMETERY 4 Donation 5 Other (Specify) 8-4-95 WORTH, IL. 21. SIGNATURE OF FUNERAL SERVICE LINENS STERLING ASHTON FUNERAL HOME, INC. 1102011 736 EDMONDSON AVE. BALTO, MD. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one ceuse on each line. SUBARACHNOID HEMORRHAGE DUE TO RUPTURE OF AN Approximata Intervel Between ANEURYSM OF THE RIGHT CEREBRAL ARTERY IMMEDIATE CAUSE (Finel **Onset and Death** disease or condition resulting in death) DUE TO (OR AS A CONSCOUENCE OF): CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEDUENCE OF): thet initieted events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 | NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 🖊 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Rasidence 6 □ Other (Specify) 1 Inpatient 2 XER/Outpatient 3 I DOA 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28a. PLACE OF INJURY — At home, larm, streel, factory, offica building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED. 6 Could not be 4 Homicide COMPL 1 CERTIFYING PHYSICIAN: To the best of my knowledge, daeth occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE C.M.E 2

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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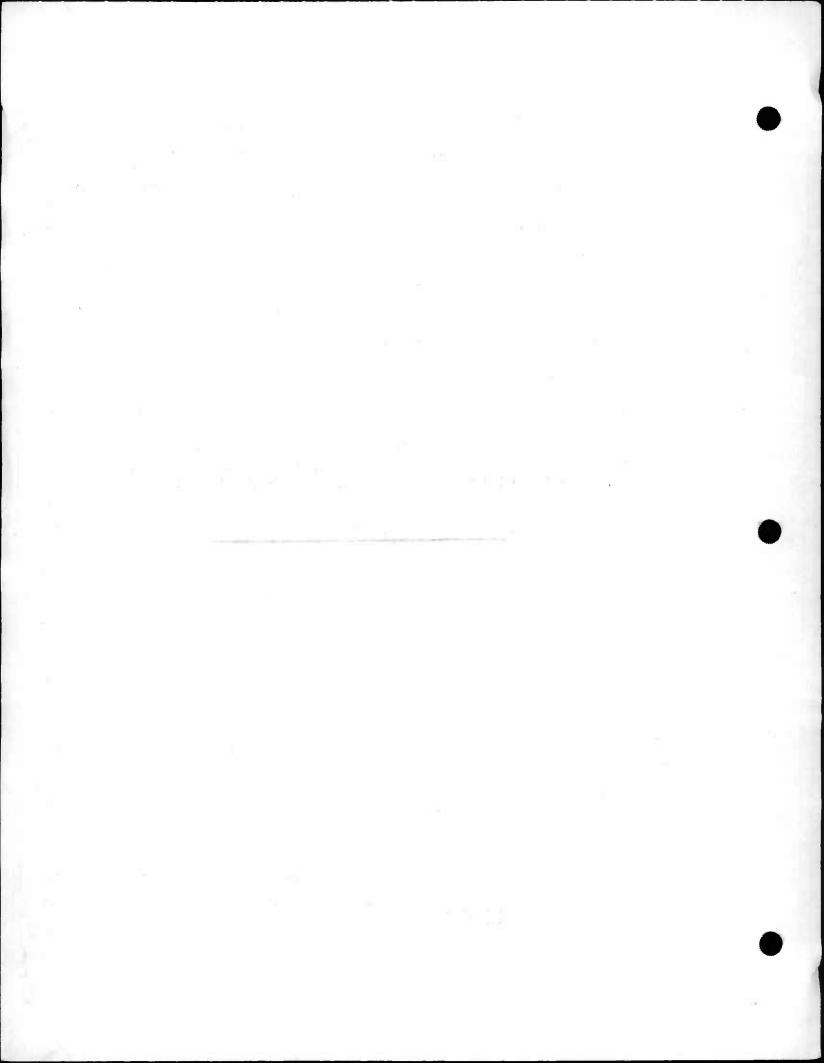
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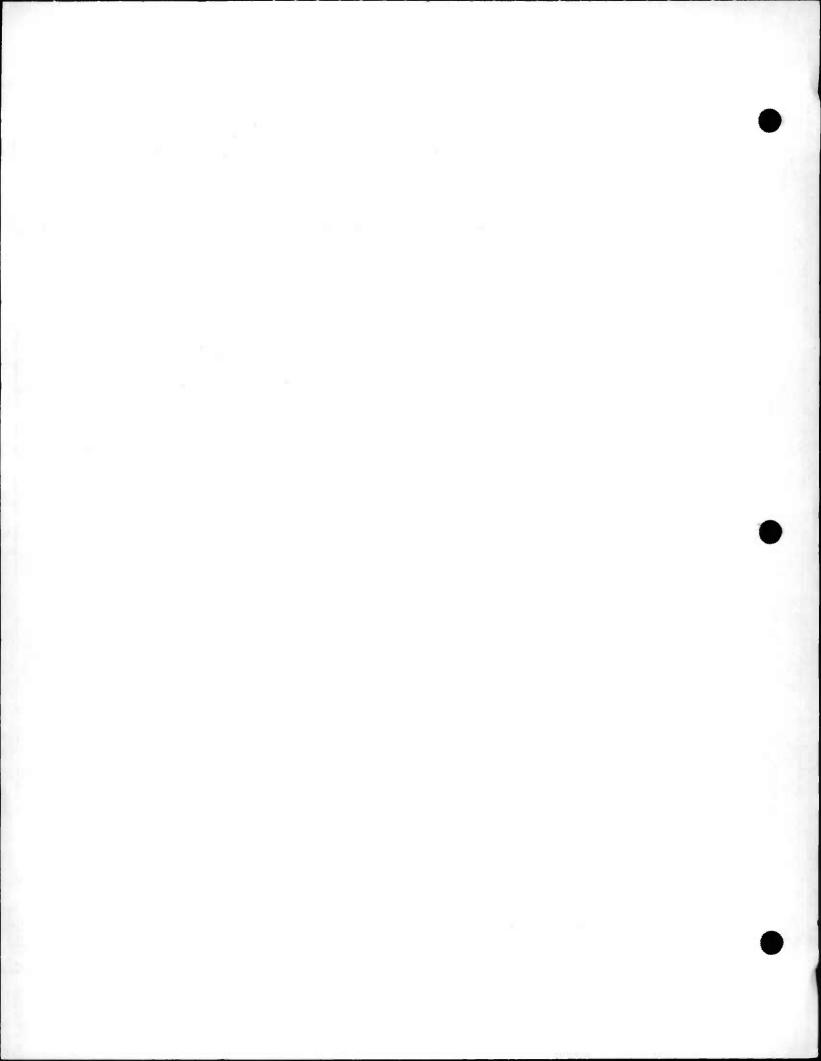
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111 Penn Street, Baltimore, Maryland 21201



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		1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEA CERTIFICATE OF DI	LTH AND MENTAL HYGIENE EATH REG. NO.							
		1. DECEOENT'S NAME (First, Middle, Last)	2. DATE OF DEATH AND YEAR 3. TIME OF DEATH AND YEAR							
		LEO A. LUCZAK SR 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF	JULY 24 1995 8:30 PM							
pinous		189-20-7678 12M2 F 68 YRS, MONTHS DAYS HO	UNDER 24 HRS. FEB 13 1927 S. BIRTHPLACE (State or Foreign Country) FEB 13 1927 PEDDSYLVANIA							
1, 2, 3 shc	DIRECTOR		OCATION OF DEATH 9c. COUNTY OF DEATH							
Pages 1	REC	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION	10d, INSIDE CITY							
permit. P		Md. BALTIMORE PARKVILL								
	NERAL		21234 USA							
21215-0020 al or attending physician. for use as the burial-transit	D BY FUN	1 Never Merried 2 W Merried FORCES? 1 YES 2 NO If yes, specify	ENT OF HISPANIC ORIGIN? (Specify Yee or No— Cuben, Mexicen, Puerto Ricen, atc.) NO Specify: NO Specify: WHITE							
1215-0 r attending use as the	ш	15. DECEDENT'S EDUCATION 180. OECEDENT'S USUAL OCCUPATION	165 KIND OF BUSINESS/INDUSTRY							
	2ET	Elementery/Secondery (0-12) College (1-4 or 5 +)	US POSTAL Service							
AND the hospital detached once.	COMPL		MOTHER'S NAME (First, Middle, Maiden Surneme)							
at Be T	BE C	Frank S. Luczak	FRANCES M. WISOloski							
MAR retained 5 should notified	10 B	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end M	lumber or Rural Route Number, City or Town, State, Zip Code)							
be a ge 5	۴		EY DR. APTE. BALTO, MD 21234							
E 6 - 5		20e, METHOD OF DISPOSITION 1	OATE 20c. LOCATION — City or Town, State							
A GE GE		COLARE VALLEY WEM	Gdns 7/28/95 TIMONIUM Md.							
ALT death. funera		EVANS C	HAPEL of MEMORIES							
y the		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of	HARFORD Rd. Balto Md. 21234 of dying, such as cardiac or respiratory arrest, Approximete							
		ahock, or heart failura. List only one cause on each line. IMMEDIATE CAUSE (Final	intarval Between Onset and Dasth							
within within pletely cremati		disease or condition resulting in death) a. PULMONARY EMB								
executed executed to burial, matic ex	NOI	Sequentially list conditions. BLADDER CANCE!	R							
be be lior tior t	CATIC	If any, laading to immediate cause. Enter UNDERLYING								
certificate ding physical physical central cen	IFIC	CAUSE (Disease or injury that initiated eventa DUE TO (OR AS A CONSEQUENCE OF):								
ath cer ttending	CERTIFI	resulting in death) LAST								
KUS, P at the death by the atten and Mental I y injury, o		PART II. Other algnificant conditions contributing to death but not resulting in the underlying car								
res that the signed by the lealth and lealth	MEDICAL	COPD, CHF	PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF CRATUS							
11 2 0 1 2	ME	CVA, HTN	0F 0EATH? 1 ☐ YES 2 ☐ NO							
3 ep 2	AN:		JNCERTAIN 🗆							
et ete 1	SICIAN:	EXAMINER? HOSPITAL: OTHER:								
PHYSICIAN: this certification with the St	PHY	27. MANNER OF OEATH 280. DATE OF INJURY 28b. TIME OF 28c. INJURY	□ Residence 8 □ Other (Specify) AT 28d. OESCRIBE HOW INJURY OCCURED							
DING PHYS After this of death with	ВУ Б	1 Accident Investigation (Month, Day, Year) INJURY WORK? (Month, Day, Year) INJURY WORK? M 1 YES	2 🗌 NO							
TTEND TTOR: A after d	TED	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — Al home, ferm, atreel, fectory, office building, atc. (Specify)	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
	PLE	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end	place, end due to the cause(e) end manner se stated.							
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If	COMPLE	one) 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death	occured at the time, date end place, end due to the ceuse(e) end menner es stated.							
THE HOSPI THE FUNEF filed within	BE C	1/20	LICENSE NUMBER 29d. OATE SIGNEO (Month, Day, Year)							
₽ ₽ 2 %	70	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	0-06-069 DULY 27, 1995							
		11 11 11 11 11 11	or Keal lack power of edge Rolling							
		31. DATE FILEO (Month, Day Year) / 32 BEGISTRAR'S SIGNATURE	MC. 5601 LOCH RAVEN BLV- Baltimor							
		AUG 0 2 1995 July 10 10 10 10 10 10 10 10 10 10 10 10 10								



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BALTIMORE, MARYLAND ?	Dans & may be retained by the honeital
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TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withhere? hours after death. Page 6 may be retained by the hospital or attending physician.

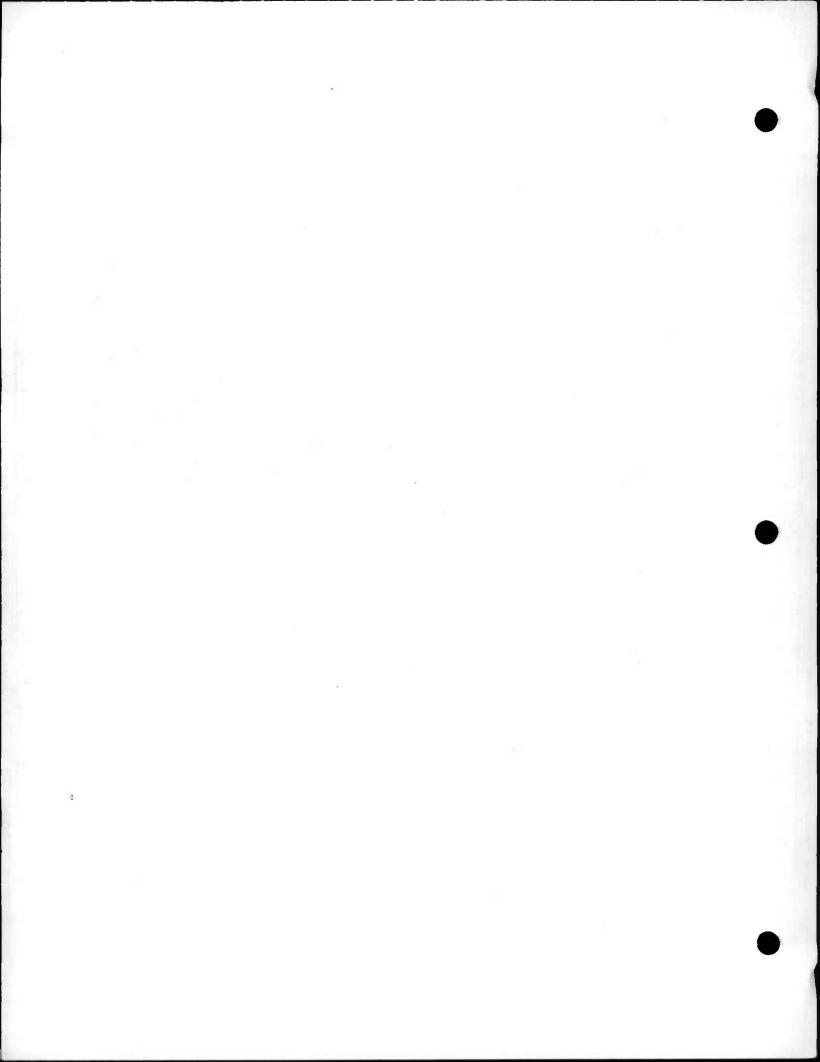
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68769

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF																	
	Harriet	LOW	Lowery					MONTH	25.		YEAR	10:45 A M					
	4. SOCIAL SECURITY NUME	BER	5. SEX 6. AGE (In yrs. last birti			F UNDER 1 YEAR IF UNDER 24 HRS.			7. DATE OF BIFTH 8. B.				IRTHPLACE (State or Foreign				
	212-26-9454		1 M 2 T-F			MONTHS DA		HOURS MIN.		(Month, D	lay, Ybar)	1010	Countr	y)			
	9e. FACILITY NAME (If not in	/	77 YRS.			OR LOCATI	ON OF D	July	ΤΩ .		NOT	rth Carolina					
Œ							LAIN				CAIN						
5	1221 North			Baltimore n/a						<u>/a</u>							
DIRECTOR	10e. STATE		10c. CITY,			TION						10d. INSIDE CITY					
											- 1	LIMITS?					
AL	10e. STREET AND NUMBER									ZEN OF WHAT COUNTRY?							
FUNERAL	1221 North	Augusta	a Avenue	21229					USA								
5	11. MARITAL STATUS	IT EVER IN U.S. A				DECENDENT OF HISPANIC ORIGIN			Specify Yes	- American Indian,							
	1 Never Married 2 💢			YES 2 X				If yes, specify Cuben, Mexicen, Puerto 1 YES 2 XNO Specify:					erto Rican, atc.) Black, White, e Specify:				
ВУ	3 Widowed 4 Divo	rced					Specify.						Bl.ack				
COMPLETED	15. DEC (Specify only	EDENT'S EDUC y highest grade	CATION completed)	0	ECEDENT'S	work done	CCUPATIO	ON st of working	na	16b. Ki	ND OF BUS	INESS/INE	DUSTRY				
<u>"</u>	Elementary/Secondary (0	1-12)	College (1-4 or 5	+)	e. Do NOT u	se retired.)											
MP	10th Grade			I	Domes	tic I	Work	er		F	rivat	te Fa	amili	ies			
8	17. FATHER'S NAME (First, M	iddle, Last)						18. MOT	HER'S NA	ME (First, Mide	die, Maiden S	Sumame)					
H	Daniel Johns									Coefi							
2	19e. INFORMANT'S NAME (7	ype/Print)		19	Db. MAILING	ADDRES	S (Street e	nd Number	r or Rural I	Route Number,	City or Town	, State, Zip	Code)	21229			
-1	Robert Lowe:				1221	Nort	n Au	gust	a Av	enue	Balt	imor	ce, N	Maryland			
	20e. METHOD OF DISPOSITI	ION on 3 ☐ Remo	ovel from State	20b. PLACE cemetery, cr	AND DATE	OF DISPOS	SITION (Na	ame of		DATE	20c. LOC	CATION —	City or To	wn, State			
	4 Donalion 8 Dottec		/	Arbút	us Me	mori	al. I	Park		2/9	Ba1	timo	re C	ounty, MD			
- 1	21. SIGNATURE OF FUNERIA	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Home											Homes, Inc.				
	1 has	00	nu. X	drui7	N	25	501	Gwyn	ns F	alls F ryland	arkwa	ay					
	23. PART I. Enter the d	sesses, or c	omplications the	t caused the d	eeth. Do i	not enter	the mo	de of dv	Ing. suc	LVIANO	or respir	atory an	reat	Approximete			
	anock, or n	eert tallure. L	List only one cau	use on each lin	e.			,		1.7				interval Between Onset and Death			
IMMEDIATE CAUSE (Fine) disease or condition										H.							
- 1				Cac	11 1000	Add and	2.1	7. ,									
	resulting in death)	→ ,	DUE TO	(OR AS A CONSE	Q O	E Cope	Kat	by									
7	resulting in death)	→ ,	DUE TO	(OR AS A CONSE	OUENCE O	F):	reste	by	zla.	01 C/ C							
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CATION	Sequentially list conditi if any, leading to imme- csuse. Enter UNDERLYI	diate NG)	CAO	nar	2 9	rte	by ~107	do	v 815							
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BALTIMORE, MARYLAND 21215-0020	or death. Page 6 may be retained by the hospital or attending physician.	RECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should rs after death with the State Oept, of Health and Mental Hyglene prior to burial, cremation, or removal.	
VISION OF VITAL RECORDS, P.O. BOX 68760	ATENDING PHYSICIAN: The law requires that the death certificate be executed within-res hours after death. Page 6 may be retained by the hospital or attending physician.	KECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi rs after death with the State Oept. of Health and Mental Hyglene prior to burial, cremation, or removal.	

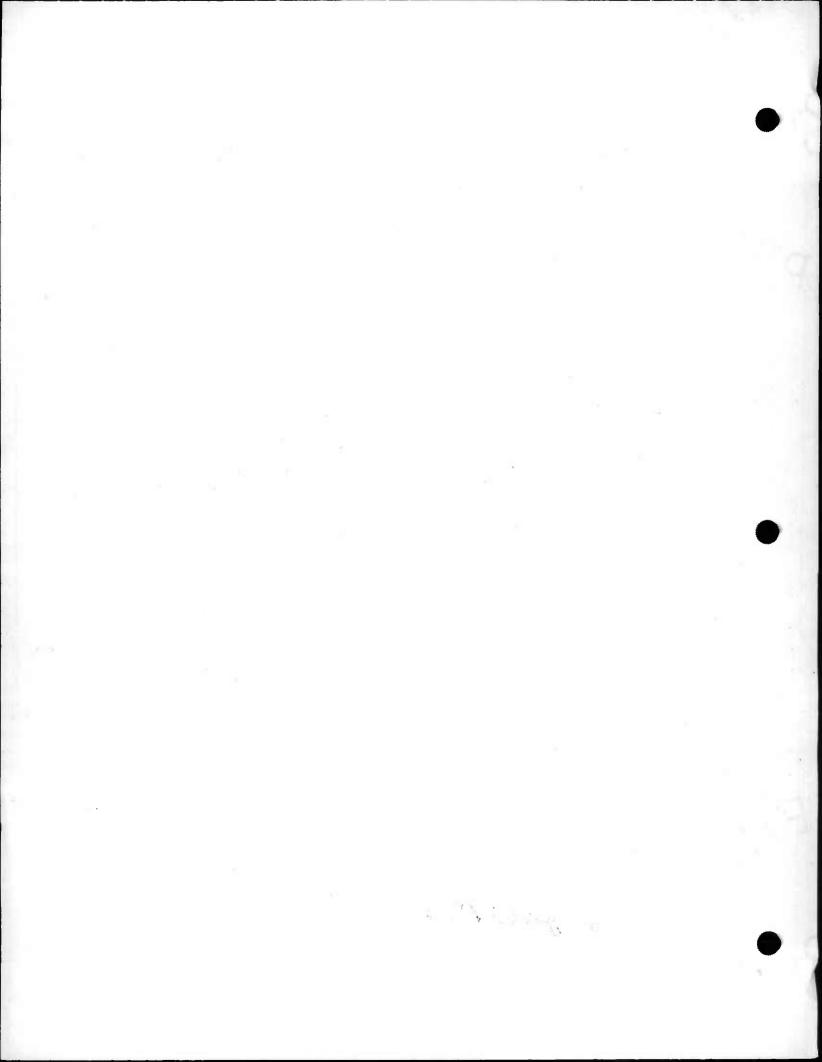
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH JÜĽY 1995 AR **JOHN** LONG, Sr. 04:37 AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR 218-12-4050 DAYS HOURS 1 [X M 2] F 70 SEPT. Maryland 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR 2695 ST. BENEDICT STREET BALTIMORE N/A RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Va. N/A New Church 1 YES XX NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3017 Davis Road 23415 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIf yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 X NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried BY 3 Widowed 4 Divorced Specify. white WWII COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 8 N/A Truck Driver All Supply & Parts 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at William Long BE Sophia Myers 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Rosemary Long 3017 Davis Rd., New Church, Va. þe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State must Crownsville Veterans Cem. 4 ☐ Donation 5 ☐ Other (Specify) 7/31 Crownsville, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 21227 medical 23. PART /Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. intervai Between IMMEDIATE CAUSE (Finel Oneat and Death the state disease or condition Schote teus. resulting in death) event, CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? any 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: 1 XYES 2 NO 1 - Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 X Residence 8 Other (Specify) 27. MANNER OF OEATH 28b. TIME OF INJURY 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Accident 5 Pending 1 YES 2 NO В Investigation 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, lectory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined 69 COMPLETED 4 Homicide 28 TO THE HOSPITAL OR AT
TO THE FUNERAL DIRECT
be filed within 72 hours a
IMPORTANT: It item 2 29a. CERTIFIER (Check only one) 1 ___ CERTIFYING PHYSICIAN: To the beet of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner ee stated. 2 MEDICAL EXAMINER: On the beets of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end menner ea stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

JULY 27 1995 BE O.C.M.E. 111 Penn Street, Baltimore, Maryland 21201 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) No OU

DHMH-16 Rev 1/89

AUG 0 2 1995



YEAR

95

2. DATE OF DEATH MONTH D

DAY

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

MARY IRENE MRYNCZA

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		4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE	(In yrs. last birthday)	IF UNDER	1 YEAR	IF UNDER 24 HRS		ATE OF BIRTH	8.	BIRTHPL	ACE (State or Foreign	
27		218-60-8223	1 M 2 F 88 YRS.			MONTHS DAYS HOURS MIN.				-26-07	PENNSYLVAN			
3 should	l l	9e. FACILITY NAME (If not institution, give a	treet and number)			9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEAT								
6,	O. H	DEATON NURSING	CENTER			BALT	ГІМІ	ORE			N/	А		
←*	CTO	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	,		40.00	V 701101 0								
permit. Pages	. DIREC	MARYLAND BAL	TIMORE		10e. CIT	y, town o		TIMOR	E				d. INSIDE CITY LIMITS? YES 2 NO	
The T	¥	10s. STREET AND NUMBER	0.1100.111100				- 1	. ZIP CODE				N OF WHA	T COUNTRY?	
ransi	FUNERAL	3026 TENNESSEE AVENUE 21227 USA												
fing physician.	B	11. MARITAL STATUS 1 Never Merried 2 Married 3 X Widowed 4 Divorced	YES	VER IN U.S. ARMED YES 2 NO OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Mexican, Puerto Rican, atc.) 1 ∨ YES 2 NO Specify: 14. RACE Black, Specify W ⊢ I T								American Indian, hite, etc.		
r attending		15. DECEDENT'S EDUC (Specify only highest grade	CATION		16e. DECEDENT'S	USUAL OC	CUPATIO	ON	T	16b. KIND OF BUS				
for u	E I	Elementary/Secondary (0-12)	College (1-4 or 5+) (Give kind of water the black of the			vork done d se retired.)	luring mo	st of working						
the hospital or detached for u	MP	6 YEARS			HOMEMA	KER				OWN	I HOM	E		
by the	E COMPL	17. FATHER'S NAME (First, Middle, Lest) STANLEY ROMECK	I					16. MOTNER'S UNKNO		irst, Middle, Maiden S	Surname)			
retained 5 should notified	TO B	19a. INFORMANT'S NAME (Type/Print)								Number, City or Town	, State, Zip Co	de)		
2 2 2	-	MR. ADOLPH MRYN	CZA	- 11	3026	TENN	IES:	SEE AV	Ε.	BALTO.	MD.	2122	27	
		20a. METNOD OF DISPOSITION 1, Burlel 2 Cremation 3 Remo	ovat from Stata		netery, crematery-or-ex				4		CATION — CITY			
2 2 2		4 Donation 5 Other (Specify)		I H	OLY PERROS	_		METERY	_	-31 BAL	.TO.	co.	MD.	
death. Pag funeral di f. examiner	1	11111	1//		1.			DROWSK		UNERAL	HOME			
2 9 2 8	ш	Charles X.	Xacta	MU	Lake	25	525	FLEET	ST	. BALTO	. MD	. 21	224	
hours or re		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final											Approximata Interval Batw Onset and D	
within pletely cremati vent, t		disease or condition resulting in death) a. After F5 c/erofic Cardio Vas cular Disease DUE TO (OR AS A CONSEQUENCE OF):											4479	
tre be executed ysician and comprior to burial, traumatic ex	CATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING												
eath certificate attending physic tal Hygiene pri	CERTIFIC	CAUSE (Disease or Injury that initiated events resulting in daath) LAST	C										 	
- E E	핑													
that the the the the the the the the the th	EDICAL	PART II. Other significant condition	s contributing to	death t	out not rasuiting i	n the und	deriying	cause given	in Part	1 YES 2	WED?	AM	RE AUTOPSY FINDI MILABLE PRIOR TO MPLETION OF CAU	
requires the seen signed of Health and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show and shows a show	ME			_						1.0	200	OF DEATH?		
	ä	DID TOBACCO USE CONTR	RIBUTE TO CA	USE C	F DEATH YE	S 🗆 N	10 [UNCERTA	IN E					
ate ate	SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	V/	26. PLACE OF DEAT	OTHER	:	e 5 🗆 Residenc	• 6 □ ı	Other (Specify)				
vsicial s certifi th the	PHY	27. MANNER OF DEATH	26a. DATE OF (Month, D	INJURY	28b. TIMI	-	28c. INJ	URY AT	7	DESCRIBE HOW IN	JURY OCCUR	ED		
NG PHY fter this eath with	ВУ	1 Netural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO												
TTENDI TOR: A after d	ETED E	3 Suicide 6 Could not be determined 26s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 26s. LOCATION (Street and Number or Rural Rout City or Town, State)									Rural Floute	Number,		
世 当 な 単	COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as												
THE HOSPITHE FUNER filed within PORTANT:		29b. SIGNATURS-AND TITLE OF CERTIFIES			11/1		- 1	Mc. LICENSE N		383000000000000000000000000000000000000			nth, Day, Year)	
TO THE TO THE De filed	BE	120010	- 2	6	Marc	10	2	1)2	1/3		DATE SI	GNED (MO	7 7 100	
663₹	오	30. NAME AND ADDRESS OF PERSON WNO	COMPLETED CAUS	E OF DE	ATN (ITEM 27) (Type,	Printy .	\rightarrow	()31	100	2	00	19	4, 199	
		31. DATE FILED (Month, Day, Year)	fallace	11	0 6/1	15	. (Char	105	St. Bai	1 tma	e M	1 212	
0		AUG 0 2 1995	RECISTRA	H GIGN	ALL STREET									

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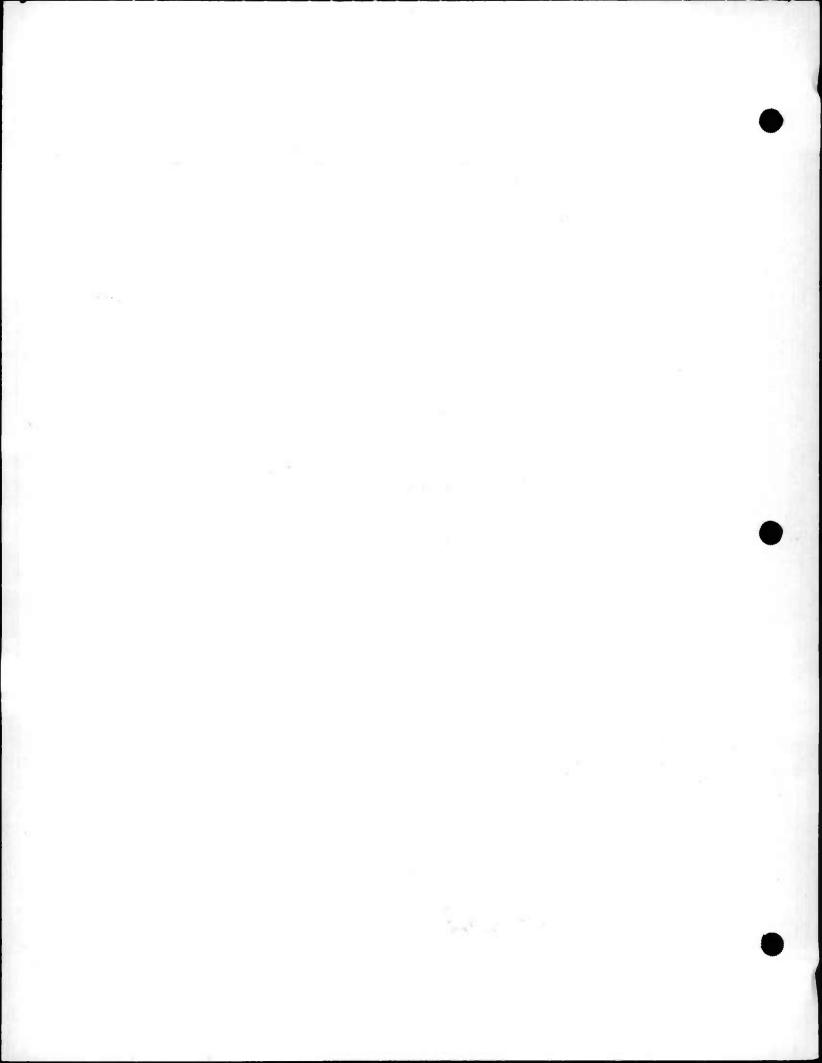
3. TIME OF DEATN

Approximata Interval Batween **Oneat and Death**

8. BIRTHPLACE (State or Foreign PENNSYLVANIA

10:30A M

24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) due to the cause(s) end menner as stated. the time, date and place, and due to the cause(s) end manner as stated. 29d. DATE SIGNED (Month, Day, Year) DHMH-16 Rav 1/89



FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR GARY MITCHELL JULY 24 1995 7:50 P. 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. lest birthday) IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAVE 1 🛛 M 2 🗆 F 218-96-4803 March 9. 1956 MARYLAND Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR IRVINGTON KNOLL NURSING HOME BALTIMORE N/A RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND N/A BALTIMORE permit. 1 X YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 131 W. CROSS STREET use as the burial-transit 21230 USA. be retained by the hospital or attending physician. ge 5 should be detached for use as the burial-trans 11 MADITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No. 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 ANO Specify: 1 🔯 Never Married 2 🔲 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced Specify: BLACK COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e, DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) UNKNOWN LABORER BOY DISTRIBUTER COMPANY once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumame) **JAMES** 7 MITCHELL BE ELSIE BUTLER funeral director, page 5 should notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 **JAMES** MITCHELL CROSS STREET, BALTIMORE, MARYLAND 21230 pe 20e, METHOD OF DISPOSITION
1 X Burlal 2 Cremation 3 Removal from State 24 hours after death. Page 6 may 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must metery, crematory of other place!
MT. ZION CEMETERY 4 Donation 5 Q Other (Specify) BALTIMORE, MARYLAND 7-28-95 medical examiner JOSEPH H. BROWN JR FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTO. MD. 21223 21. SIGNATURE OF FUNERAL SERVICE LICENSES n by the I filled in by 1 23. PART I. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feliure. List only one ceuse on each line. cremation, or Interval Between IMMEDIATE CAUSE (Final Onset and Death event, the disease or condition_ Hepana Encephelopethy completely resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF): and com Se124re disorder traumatic CERTIFICATION Sequentially list conditions, attending physician are ental Hygiene prior to DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be CirchosisofLiver other t CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST Cerebra! Vasenur accident 10 the atten PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS and and AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any Hypertension. signed t 1 TYES 2 NO shows a Cardio-ph/mongry arrest 1 | YES 2 | NO been f. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO W UNCERTAIN I PHYSICIAN: Dept. certificate has t 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTNER:
| Nursing Home | 5 | Residence | 8 | Other (Specify) 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA the 27. MANNER OF DEATH 26a. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED this c marked, 1 YES 2 NO BY After Investigation Accident DIRECTOR: Afr hours after de-item 28 is n 28a. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide TO THE HOSPITAL DR ATT TO THE FUNERAL DIRECTL DE filed within 72 hours at IMPORTANT: If item 21 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE CERTIFIER 8 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D30115 7/28/95 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ohiokpehai, mo 2600 LIBERY HOTS AVE. Baltimore, mo 21215 52 REGISTRAN'S SIGNATURE 31. DATE FILED (Month, Day, Year) AUG 0 2 1995

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

